

DEPT.-65

JOB- 21

REEL- 19

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910



CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE
RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT
THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE
DEPARTMENT OF Health BUREAU OF Vital
Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS
AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COM-
PLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PRO-
VIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION
NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN
ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR
ON JUNE 4, 1954.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No.

345

Department:

Health

Bureau:

Vital Statistics

Record Identification

1. TITLE: Certificate of Death		2. Form No. if available		3. Type—(cards, paper, etc.) Bound Book	
4. Dates	5. Volume accumulated yearly	6. Size of Record Misc.	7. Number of copies made One (1)		
8. Authorization Requested (check only one (1) of the squares below)					
A. Establish retention period for <input type="checkbox"/> records which are accumulating daily.		B. Dispose of present accumulation, no additional accumulation anticipated. <input type="checkbox"/>		C. Microfilm and destroy originals. <input type="checkbox"/>	
				D. Microfilm and retain originals for length of time indicated below. <input checked="" type="checkbox"/>	
9. Recommended Retention Period			10. Equipment and space freed.		11. In your opinion does this record have any historical significance?
a. In Dept. 12 yrs.		b. In Storage Center Micro. Perm.		c. Total 12 yrs. and Micro. Perm.	
			YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>
12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)					

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.
Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval

Robert E. Fairley, M.D.
Title: Commissioner of Health

3/28/63
Date

Recommendation of Records Management Officer

13. Recommended Retention Period			14. Disposal Method		
a. In Dept. 12 yrs.	b. In Storage Center Microfilm Permanent	c. Total 12 yrs. and Microfilm Permanent	A. To be sold as scrap or waste paper <input type="checkbox"/>	B. To be Burned or shredded <input checked="" type="checkbox"/>	C. Historical, (to be transferred to Dept. of Legislative Reference.) <input type="checkbox"/>
REMARKS: 2 negative Rolls					
			C. P. Force		3/18/63
			Records Management Officer		Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents
were received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85351

CERTIFICATE OF DEATH.

C85351

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2229 E. Biddle ST.; 8 WARD)

2-FULL NAME

Residence in Baltimore: No. 2229 E. Biddle St.; 79 yrs., 7 mos., 8 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE.

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) widow

6-DATE OF BIRTH.

October 6, 1835
(Month) (Day) (Year)

7-AGE.

79 yrs., 7 mos., 8 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country).Balto City

PARENTS.

10-NAME OF FATHER.

John B. Newwiler11-BIRTHPLACE OF FATHER
(State or Country).Germany

12-MAIDEN NAME OF MOTHER.

Phanna Stoker13-BIRTHPLACE OF MOTHER
(State or Country).Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Lloyd(Address) 2229 E. Biddle

15-

MAY 16 1915

Filed

ROBERT KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 15th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 10th, 1915, to May 15th, 1915, that I saw him alive on May 15th, 1915, and that death occurred, on the date stated above, at 2 P.M. The CAUSE OF DEATH* was as follows:Myocardial degeneration, and
arteriosclerosis.
(Duration) 6 yrs., 6 mos., 8 ds.CONTRIBUTORY
(Secondary)(Duration) 6 yrs., 6 mos., 8 ds.
(Signed) Robert Krauter, M.D.
May 15, 1915 (Address) 2229 E. Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 79 yrs., 7 mos., 8 ds. In the State 79 yrs., 7 mos., 8 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Balto - Cem

DATE OF BURIAL.

May 16, 1915

20-UNDERTAKER

Wm. Boast

ADDRESS

2229 E. Biddle

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85352

CERTIFICATE OF DEATH.

79 C85352
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *127 S. Burkham* ST. *2* WARD)

2-FULL NAME

(Residence in Baltimore: No. *127 S. Burkham* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *widow*

6-DATE OF BIRTH,

November 7, 1872
(Month) (Day) (Year)

7-AGE,

*72 yrs. 5 mos. 8 ds.*If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

at home

9-BIRTHPLACE,

(State or Country), *Germany*

10-NAME OF FATHER,

Valentine Burkline

11-BIRTHPLACE OF FATHER

(State or Country), *Germany*

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *George J. Paulus*(Address), *127 S. Burkham St.*

15-

MAY 16 1915

ROBERT J. KRAUTER,

Filed..... 191.....
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 *15*, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 14 191*5*, to *May 15* 191*5*,that I saw her alive on *May 15* 191*5*,and that death occurred, on the date stated above, at *11:45 am*.

The CAUSE OF DEATH* was as follows:

Valvular Heart Lesion

.....

.....

.....

..... (Duration) yrs. *6* mos. ds.CONTRIBUTORY (Secondary) *Pulmonary Edema*..... (Duration) yrs. mos. *2* ds.(Signed) *J. W. ...* M. D.*May 15, 1915* (Address) *148 S. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

.....

19-PLACE OF BURIAL OR REMOVAL,

*St. Ashmun St. Cem*DATE OF BURIAL, *May 18, 1915*20-UNDERTAKER, *Wm. ...*ADDRESS *3078 N. ...*

important. See instructions on back of certificate.

885353

HEALTH DEPARTMENT—CITY OF BALTIMORE

885353

CERTIFICATE OF DEATH.

28

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

CITY OF BALTIMORE (No. 2528 Maryland Ave 12th

REGISTERED NO. C

FULL NAME Mary C. Jones

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2528 Maryland Ave

St.; yrs., 49 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH

Jan 15, 1866

7-AGE

49 yrs. 2 mos. 29 ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

House work

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Dennis Kane

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Eliza Badger

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Jones

(Address) 2528 Maryland Ave

15-

MAY 16 1915

ROBERT J. KRAUTER,

Sanial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 15, 1915

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Phthisis Pulmonalis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Hange K. M. D.

(Address) 3640 N. ...

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

May 17, 1915

20-UNDERTAKER

Geo W Little

ADDRESS

531 N. ...

C85354

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

50 C85354

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *7 N Schward* ST. *18* WARD)2-FULL NAME *Mary Hughes*(Residence in Baltimore: No. *7 N Schward* St.; *40* yrs. *40* mos. *40* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Wht* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Married*6-DATE OF BIRTH *July 12 1852* (Month) (Day) (Year)7-AGE *62* If LESS than 1 day, hrs., min. 1 day, hrs., min. 2 yrs. mos. ds. or min.?8-OCCUPATION (a) Trade, profession or particular kind of work *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE (State or country) *Ireland*10-NAME OF FATHER *Patrick Nolan*11-BIRTHPLACE OF FATHER (State or country) *Ireland*12-MAIDEN NAME OF MOTHER *Honora Hughes*13-BIRTHPLACE OF MOTHER (State or country) *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Emily Hught*(Address) *7 N Schward*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 14 1915* (Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Apr 23 1915* to, *May 14 1915*, that I saw h. alive on *May 14 1915*, and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH* was as follows:

*Diabetes Mellitus*Contributory (SECONDARY) *Coma* *Diabetes* (Duration) *1* yrs. *4* mos. *4* ds.(Signed) *J. J. Moore* M. D. *May 10 1915* (Address) *939 N. Fayette*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *40* yrs. *40* mos. *40* ds. In the State *40* yrs. *40* mos. *40* ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *New Cathedral* DATE OF BURIAL *5 18 1915*20-UNDERTAKER *H. C. Branning & Son* ADDRESS *517 N. Schward*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15- MAY 16 1915 ROBERT J. KRAUTER, REGISTRAR

Burial Permit Clerk

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

85356

CERTIFICATE OF DEATH

40 85356

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1839 N. Bond

ST. 8 WARD)

FULL NAME *Marick Wehlman*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

Residence in Baltimore: No. 1839 N. Bond

St. 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

16 DATE OF DEATH

Male

White

Married

May

13th, 1915

6 DATE OF BIRTH

June 30th, 1849

7 AGE

65 yrs. *10* mos. *13* ds. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Printer

9 BIRTHPLACE
(State or country)

Baltimore Md.

10 NAME OF FATHER

Frederick Wehlman

11 BIRTHPLACE OF FATHER
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Lena Kerner

13 BIRTHPLACE OF MOTHER
(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Wehlman

(Address)

1839 N. Bond

17. I HEREBY CERTIFY, That I attended deceased from

March 10th, 1915 to *May 13th, 1915*

that I saw him live on *May 12th, 1915*

and that death occurred, on the date stated above, at *4:30 P.M.*

The CAUSE OF DEATH* was as follows:

*Exhaustion of Stomach
(Clinical Diagnosis)*

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *Steen L. Singen*

5/14/1915 (Address) *1563 E. North*

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

May 17th, 1915

20 UNDERTAKER

ADDRESS

D & M. J. Flynn

1122 E. 11th St.

MAY 16 1915

ROBERT KRAUTER,

Sanial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85357

CERTIFICATE OF DEATH.

151 C85357

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Baker

ST.: 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Edwin Barton

(Residence in Baltimore: No. 1801 Baker

St.: yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED, *baby*,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 27, 1915
(Month) (Day) (Year)

7-AGE,

yrs. mos. 1.8 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work. *Noice*
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF
FATHER,

Edwin J. Barton

11-BIRTHPLACE
OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME
OF MOTHER

Alice I. Saunders

13-BIRTHPLACE
OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edwin J. Barton*(Address) *1801 Baker St*

MAY 16 1915

ROBERT . KRAUTH

Filed

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 15, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
April 27 1915, to May 15 1915,
that I saw him alive on May 14 1915,
and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Puerperal Inanition
and Malnutrition
(Duration) yrs. mos. 1.8 ds.CONTRIBUTORY
(Secondary)(Duration) yrs. mos. ds.
(Signed) Charles E. Clark M. D.

May 16 1915 (Address) 1310 N. Gilman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Woodlawn Cem May 16 1915

20-UNDERTAKER

ADDRESS

H. H. Wilson for North

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085358

HEALTH DEPARTMENT—CITY OF BALTIMORE

120

085358

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1009 N. Carlton street, St. 18 WARD)

2-FULL NAME William G. Perkins,

(Residence in Baltimore: No. 1009 N. Carlton street, St.; yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, Married, (Write the word.)

6-DATE OF BIRTH, August 2nd, 1852. (Month) (Day) (Year)

7-AGE, 62 yrs., 2 mos., 13 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Day laborer, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Virginia,

10-NAME OF FATHER, Robert Perkins,

11-BIRTHPLACE OF FATHER (State or Country), Virginia,

12-MAIDEN NAME OF MOTHER, Harriet Jones,

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fatsy Perkins, wife,

(Address) 1009 N. Carlton street.

MAY 17 1915

HARRY O. ANDREWS,

Filed, 101, Burial Permit, Q. 101, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis, et vesicoperineal fistula.

(Duration) yrs. mos. ds.

CONTRIBUTORY. Fistula was post-

operative (Secondary) (Duration) yrs. mos. ds.

(Signed) J. H. H. M. D. (Coroner.)

May 15th 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS,

Geo. H. Cooper 609 S. W. 11th

C85359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

93 C85359
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 Etting St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Sarah Stratton Brown

(Residence in Baltimore: No. 2018 Etting St. yrs. 1 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. Col. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)

6-DATE OF BIRTH. March 3, 1870 (Month) (Day) (Year)

7-AGE. 45 yrs. 2 mos. 11 ds. 11 LESS than 1 day.hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cook
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). West Virginia

10-NAME OF FATHER. George McCann.

11-BIRTHPLACE OF FATHER (State or Country). West Virginia

12-MAIDEN NAME OF MOTHER. Don't know

13-BIRTHPLACE OF MOTHER (State or Country). Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Robinson

(Address) 2016 Etting St.

15- MAY 17 1915 HARRY O. ADAMS, Registrar.
Filed 1915 Burial Permit 910

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 26 1915, to May 14 1915, that I saw her alive on May 14 1915, and that death occurred, on the date stated above, at 8:30 P. M. The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY Chronic Neuritis (Secondary) X

(Duration) yrs. 2 mos. 24 ds.

(Signed) Paul Brown M. D.

May 15, 1915. (Address) 1837 Pennsylvania Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mont Auburn

DATE OF BURIAL,

May 17, 1915.

20-UNDERTAKER

John A. Green

ADDRESS

1227 Avenue St

important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C. 152 085360

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8)

Hebrew Hospital

ST. 3

WARD)

2-FULL NAME

Baby Bass

(Residence in Baltimore: No. 321 S. Bond

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female	4-COLOR OR RACE White	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
6-DATE OF BIRTH May 16, 1915 (Month) (Day) (Year)		
7-AGE If LESS than 1 day, 4 hrs. yrs. mos. ds. or min.?		
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None		

9-BIRTHPLACE
(State or country)

Maryland

PARENTS

10-NAME OF FATHER

Bennie Bass

11-BIRTHPLACE OF FATHER
(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Jennie Rosenberg

13-BIRTHPLACE OF MOTHER
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Leur's
1419 E. Baltimore St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16, 1915, to May 16, 1915, that I saw her alive on May 16, 1915, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

Contributory
(SECONDARY)

(Signed)

5/16, 1915 [Address] Hebrew Hosp

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. 4 hrs. In the State yrs. mos. 4 hrs.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Hebrew Rosedale

DATE OF BURIAL

May 17, 1915

20-UNDERTAKER

Jack Leur's

ADDRESS

1419 E. Baltimore St.

MAY 17 1915

LARRY O. ANDREWS,

Marial Permit Clerk

REGISTRAR

C85361

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

C85361

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3418 Harford ave

ST.

WARD

9

2-FULL NAME

George F Lamley

(Residence in Baltimore: No.

3418 Harford ave

St.: — yrs., — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

June 22, 1861
(Month) (Day) (Year)

7-AGE,

53 yrs., 10 mos., 28 da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)...

Deutch Bros

9-BIRTHPLACE, (State or Country),

Baltimore Co Md

10-NAME OF FATHER,

Jacob F Lamley

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Co Md

12-MAIDEN NAME OF MOTHER

Elizabeth Edmon

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eleanor Lamley

(Address) 3418 Harford ave

MAY 17 1915

HARRY O. ANDREWS,

Filed..... 191... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1 - 1915, to May 15 1915, that I saw him alive on May 14 1915, and that death occurred, on the date stated above, at 9:40 a.m.

The CAUSE OF DEATH* was as follows:

Malarial Paroxysm of Inguinal & Lumbar Glands, malarial fever, and Cholera. (Duration) 5 yrs., 4 mos., 28 da.

CONTRIBUTORY (Secondary)

(Signed) J. W. Schilling M. D.
May 15, 1915 (Address) 108 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Lind Ridge Cem.

DATE OF BURIAL,

May 15, 1915

20-UNDERTAKER

George Schilling & Son 1126 E. Monument

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85362

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *2315*)

ST. *19* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Miss Annie Tate

(Residence in Baltimore: No. *1529 W Fayette*)

St. *20* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6-DATE OF BIRTH *Unknown*, *1*
(Month) (Day) (Year)

7-AGE *70* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *Seamstress*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Bryansville Pa*

PARENTS
10-NAME OF FATHER *(Unknown) Tate*
11-BIRTHPLACE OF FATHER (State or country) *Pennsylvania*
12-MAIDEN NAME OF MOTHER *Unknown*
13-BIRTHPLACE OF MOTHER (State or country) *Pennsylvania*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Gamilla B Wright*

(Address) *2572 Guilford ave*

15-
MAY 17 1915

HARRY O. AELRLW'S

Bureau of Health
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 16th 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *May 6th 1915* to *May 16th 1915* that I saw her alive on *May 15th 1915* and that death occurred, on the date stated above, at *8:45 a.m.*
The CAUSE OF DEATH* was as follows:

Hyperstatic Pneumonia

(Duration) *4* yrs. mos. ds.
Contributory *Cerebral Hemorrhage*
(SECONDARY)

(Duration) *9* yrs. mos. ds.
(Signed) *Leslie C. Sturgis* M.D.
May 16th 1915 (Address) *122 W. 23rd St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *1* yrs. mos. ds. In the State *1* yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Delta Pennsylvania* DATE OF BURIAL *May 18th 1915*

20-UNDERTAKER *George Schilling & Sons* ADDRESS *1126 E. Monument*

C85363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 REGISTERED NO. C

C85363

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *8 N. Bruce* ST.: *19* WARD)2 FULL NAME *James E. Tullan*(Residence in Baltimore No. *8 N. Bruce*)St.: *30* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and All out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE. *Black*5-SINGLE, *Married*6-DIVORCED, *Never*

(Write the word.)

6-DATE OF BIRTH. *Unknown*, *1873*

(Month)

(Day)

(Year)

7-AGE, *42*

yrs.

mos.

ds.

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), *W.S.*10-NAME OF FATHER, *James M. Tullan*11-BIRTHPLACE OF FATHER, *W.S.*12-MAIDEN NAME OF MOTHER, *Eliza Brown*13-BIRTHPLACE OF MOTHER, *W.S.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Nessie Tullan*(Address) *3212 Barclay*

15-

MAY 17 1915

HARRY O. ANDREWS,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 15, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 3, 1915*, to *May 15, 1915*,that I saw him alive on *May 14, 1915*, and that death occurred, on the date stated above, at *7 PM* in.

The CAUSE OF DEATH* was as follows:

Acute Nephritis(Duration) *2* yrs. *2* mos. *2* ds.CONTRIBUTORY (Secondary) *Uremia*(Duration) *2* yrs. *2* mos. *2* ds.(Signed) *E. H. ...* M. D.*May 15, 1915* (Address) *24 N. Tullan St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. ...*DATE OF BURIAL, *May 17, 1915*20-UNDERTAKER, *Sam H. ...*ADDRESS, *100 N. ...*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85364

CERTIFICATE OF DEATH.

151 C85364

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Wilhelm St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and add out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1906 Wilhelm St.)

St.: yrs. mos. 1 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 17 1915

LARRY O. ANDREWS

BARIAT Permit 018 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia. Birth

CONTRIBUTORY (Secondary)

(Signed) Edward P. Smith M. D. 5-16, 1915. (Address) 1400 N. E. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1906 Wilhelm St.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Peter's Cemetery May 1, 1915

20-UNDERTAKER

Geo. A. Lerby Baltimore

important. See instructions on back of certificate.

56

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Q85365

HEALTH DEPARTMENT—CITY OF BALTIMORE

Q85365

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *Johns Hopkins Hospital St.*)
2-FULL NAME *Frances Burkowski*
(Residence in Baltimore: No. *720 S. Moly*)

167
REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St./ yrs. / mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*
4-COLOR OR RACE. *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Infant*
(Write the word.)
6-DATE OF BIRTH. *Oct*, *1913*
(Month) (Day) (Year)

7-AGE, *7* yrs. *7* mos. *da.*
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Infant*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). *M. (Baltimore)*

PARENTS.
10-NAME OF FATHER. *Stephen Burkowski*
11-BIRTHPLACE OF FATHER (State or Country). *Austria Poland*
12-MAIDEN NAME OF MOTHER. *Donie Grobignia*
13-BIRTHPLACE OF MOTHER (State or Country). *Austria Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *M. F. Sadowski*
(Address) *705 S. Cum St.*

15-*MAY 17 1915*
Filed *1915* *HARRY C. ADAMS,*
Bureau of Health.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *May*, *16*, *1915*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows:

Accidental Burns (Scald)
(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) *None*
(Signed) *Elyse J. Russell* M. D. (Coroner.)
May 16, 1915. (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. *St. Stanislaus* DATE OF BURIAL. *May 17, 1915.*

20-UNDERTAKER. *M. F. Sadowski* ADDRESS. *705 S. Cum St.*

C85366

HEALTH DEPARTMENT—CITY OF BALTIMORE

150 C85366

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 Calender ST. 21 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 506 Calender, 8

St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

May 16th, 1915
(Month) (Day) (Year)

7-AGE,

31 hours
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Keeding

(Address) 506 Calender St.

15-

MAY 17 1915

FILED 1915

LARRY V. ANDREWS,
Baptist Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 16th, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

May 15, 1915, to May 16, 1915

that I saw him alive on May 16, 1915

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Patulous Foramen
trache

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John G. Schurmsberg M. D.

May 17, 1915 (Address) 1120 W. Lomb St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Cemetery May 17, 1915

20-UNDERTAKER

ADDRESS

Mrs. John H. Seufel 801 N. Fayette St.

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Q85367

HEALTH DEPARTMENT—CITY OF BALTIMORE

Q85367

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE (No. *805 E. Chase*)

2. FULL NAME

Residence in Baltimore: No. *805 E. Chase*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE,
MARRIED,
WIDOWED
OR DIVORCED

6. DATE OF BIRTH

7. AGE

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

MAY 17 1915

LAST O. ADDRESS

Burial Permit 010

REGISTRAR

31

REGISTERED No. C

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

Sec. Life. mos. ds.)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 15, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on May 14, 1915, and that death occurred, on the date stated above, at 7 A.M. The CAUSE OF DEATH* was as follows:

Tuberculosis of Intestines

(Duration) yrs. 5 mos. ds.

Contributory (SECONDARY)

2. Lactation, Trauma

(Duration) yrs. 1 mos. ds.

(Signed)

May 15, 1915 (Address) 120 E. Presn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery May 18, 1915

UNDERTAKER

ADDRESS

Chas. H. Coons & Son 118 N. Mt. Royal.

085368

HEALTH DEPARTMENT—CITY OF BALTIMORE

085368

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 E. Eager ST.: 7 WARD)

REGISTERED NO. C

2-FULL NAME James Laurence Butler

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1812 E. Eager St.: _____ yrs. _____ mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH.

April 27, 1915
(Month) (Day) (Year)

7-AGE.

yrs. _____ mos. 18 ds.

If LESS than 1 day, _____ hrs. or _____ min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE.
(State or Country).Balto Md.

10-NAME OF FATHER.

James M. Butler

11-BIRTHPLACE OF FATHER

(State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER

Angela M. Reynolds

13-BIRTHPLACE OF MOTHER

(State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James M. Butler(Address) 1812 E. Eager

MAY 17 1915

Filed..... 191. Harry O. Allen Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 15, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 27 1915, to May 15 1915, that I saw him alive on May 15 1915, and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Premature birth (6 months)

(Duration)..... yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

Inanition due to inability to assimilate (Duration)..... yrs. _____ mos. 18 ds.(Signed) A. J. Lee M. D.5/15, 1915 (Address) 1003 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. _____ mos. _____ ds. In the State..... yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St Peter's Church May 17, 1915

20-UNDERTAKER

ADDRESS

Mc Ginnis & Carroll 608 N. Potomac

important. See instructions on back of certificate.

C85369

HEALTH DEPARTMENT—CITY OF BALTIMORE

138 C85369

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3132 Foster Ave. ST. 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Beynon

(Residence in Baltimore: No. 3132 Foster Ave

St. 15 yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED, Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Aug. 13, 1893
(Month) (Day) (Year)

7-AGE,

21 yrs. 9 mos. 3 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),

Penna.

10-NAME OF FATHER,

John F. Bradbury

11-BIRTHPLACE OF FATHER
(State or Country),

Penna.

12-MAIDEN NAME OF MOTHER

Anna Bright

13-BIRTHPLACE OF MOTHER
(State or Country),

Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Beynon

(Address) 3132 Foster Ave

15-

MAY 17 1915

Filed

191

BARRY O. ATTREWS,

Baltimore Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 16, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 12th 1915, to May 16 1915, that I saw h^e alive on May 15th 1915, and that death occurred, on the date stated above, at 6²⁵ Am. The CAUSE OF DEATH* was as follows:Uremic Convulsions
Purpural

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. 14 ds.

(Signed)

May 16, 1915 (Address) 3116 W. 11th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oaklawn

May 17, 1915

20-UNDERTAKER

Zukler + Zukler

DRESS 1739

E. Cager

Important. See instructions on back of certificate.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85370

C85370

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *218 Augusta Ave* ST. *20* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mable Margaret Cook*

(Residence in Baltimore: No. *208 Augusta Ave* St.; *—* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *Married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Feb 12, 1887*
(Month) (Day) (Year)

7-AGE *28* yrs. *2* mos. *19* ds. or *—* min.?
If LESS than 1 day, hrs.

8-OCCUPATION
(a) Trade, profession or particular kind of work *Housekeeper*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Maryland*

10-NAME OF FATHER *Frederick Gouse*

11-BIRTHPLACE OF FATHER (State or country) *Germany*

12-MAIDEN NAME OF MOTHER *Katherine Steagle*

13-BIRTHPLACE OF MOTHER (State or country) *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Herman Cook*

(Address) *208 Augusta Ave*

15- *MAY 17 1915* HARRY C. ADAMS, MARIAL PERMIT CLERK REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 12, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 7, 1915*, to *May 15, 1915*, that I saw *her* alive on *May 15, 1915* and that death occurred, on the date stated above, at *7 a.m.* The CAUSE OF DEATH* was as follows:

Pneumonia (bacterial)

Contributory (SECONDARY) *Exposure to cold*

(Signed) *Thomas J. Simms* M.D.
May 15, 1915 [Address] *1025 N. Wolfe St*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Cathedral Cemetery* DATE OF BURIAL *May 18, 1915*

20-UNDERTAKER *Jonah Soper 1600 W North* ADDRESS

C85371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 C85371

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Raynor Ave St. 16 WARD)

2-FULL NAME Robert Johnson

(Residence in Baltimore: No. 2500 Raynor Ave

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Feb 28, 1866
(Month) (Day) (Year)

7-AGE,

49 yrs. 2 mos. 16 ds.

If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Watchman
(b) General nature of industry, business, or establishment in which employed (or employer). P. R. R.9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF FATHER,

Frank Johnson

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Mary Diggs

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Clark

(Address) 2500 Raynor Ave

MAY 17 1915

HARRY O. ANDREWS,

Filed..... 1915. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1 1915, to May 15 1915,

that I saw him alive on May 15 1915,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — yrs. — mos. 15 ds.

CONTRIBUTORY
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Charles E. Clark M. D.

May 16, 1915, (Address) 1310 N. Guilmer St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REPOSING, DATE OF BURIAL,

Ascension Cemetery May 18 1915

20-UNDERTAKER

Mr. Edward W. Tyeer
ADDRESS
baltimore

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hosp* ST.; *4* WARD)FULL NAME *Baby Polite*

(Residence in Baltimore: No. _____ St.; _____ yrs., _____ mos. _____ ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

Blk

5-SINGLE,

single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

May 7, 1915
(Month) (Day) (Year)

7-AGE,

4 yrs., _____ mos., _____ ds.

If LESS than 1 day,

_____ hrs. or _____ min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),*Baths City*

10-NAME OF FATHER,

*Julius Polite*11-BIRTHPLACE OF FATHER
(State or Country),*S. C.*

12-MAIDEN NAME OF MOTHER

*Shelie Cash*13-BIRTHPLACE OF MOTHER
(State or Country),*Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

MAY 17 1915

HARRY O. ANDREWS,

BAPTIST PASTOR, Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 11, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 7, 1915*, to *May 11, 1915*, that I saw her alive on *May 11, 1915* and that death occurred, on the date stated above, at *8:30 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

....., 191... (Address) *University Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? *Hospital*

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

UNIVERSITY OF MARYLAND

Commissioner Health,

FOR. WM. S. WOODALL.

MAY 15 1915

ADDRESS

FOR ANATOMICAL PURPOSES

important. See instructions on back of certificate.

C85373

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 17 1915

MAY 17 1915
Baltimore City Health Department
Registrar

Per Wm. E. WOODALL

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

4-15-1915, to 5-12-1915,

that I saw him alive on 5-12-1915,

and that death occurred, on the date stated above, at 1:28 p.m.

The CAUSE OF DEATH* was as follows:

Polio Meningitis
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) C. K. Kausenbach, M. D.

5-12-1915, 1915 (Address) Univ. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

UNIVERSITY OF MARYLAND MAY 15 1915

Baltimore City Health Department

ADDRESS

FOR ANATOMICAL PURPOSES

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85374

CERTIFICATE OF DEATH

6

C85374

PLACE OF DEATH 318 O'Hagan St., Baltimore Md

REGISTERED NO. C

CITY OF BALTIMORE (No. 318 O'Hagan St)

ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 13.)

FULL NAME Carmine Citarris

Residence in Baltimore: No. 318 O'Hagan St

Str. yrs. 16 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single

6 DATE OF BIRTH Jan 2, 1914 (Month) (Day) (Year)

7 AGE 1 yr. 4 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Dependent

9 BIRTHPLACE (State or country) Baltimore Md

10 NAME OF FATHER Charles Citarris

11 BIRTHPLACE OF FATHER (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Sgarro

13 BIRTHPLACE OF MOTHER (State or country) Italy

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Sgarro (Address) 320 O'Hagan St

15 MAY 17 1915 Filed 1915 HARRY O. ALBEN, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 16, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from May 1, 1915, to May 6, 1915, that I saw him alive on May 16, 1915, and that death occurred, on the date stated above, at 5 A. M. The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (Duration) yrs. mos. ds.

Contributory (SECONDARY) measles (Duration) yrs. mos. ds.

(Signed) Henry Lynn Smiley M. D. May 16, 1915 (Address) 1610 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St Vincent's Cem.

DATE OF BURIAL May 17, 1915

20 UNDERTAKER Lilly & Sons

ADDRESS 108 S. W. 1st St

C85375

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85375

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *17 Lloyd*)ST.; *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *17 Lloyd*)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*single*

6-DATE OF BIRTH,

May 15, 1915
(Month) (Day) (Year)

7-AGE,

1 day If LESS than 1 day,
..... yrs. mos. ds. hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... *X*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),*Balt*

10-NAME OF FATHER,

*Nunzio Rizzo*11-BIRTHPLACE OF FATHER
(State or Country),*Italy*

12-MAIDEN NAME OF MOTHER

*Anna Sportz*13-BIRTHPLACE OF MOTHER
(State or Country),*Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Nunzio Rizzo*(Address) *17 Lloyd St*

15-

MAY 17 1915

HARRY O. ALLKENS,

Filed..... 191.....

BAYARD FORNIST... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 15, 1915, to *May 16, 1915*,
that I saw him alive on *May 16, 1915*,
and that death occurred, on the date stated above, at *11* m.

The CAUSE OF DEATH* was as follows:

Essential weakness
(Duration)..... yrs. mos. ds.CONTRIBUTORY
(Secondary)*Plumtree Bldg (7th)*
(Duration)..... yrs. mos. ds.
(Signed)..... M. D.
May 16, 1915 (Address) *16 S. Bond*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the yrs. mos. ds. State

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St Vincent's Cem

DATE OF BURIAL,

May 17, 1915

20-UNDERTAKER

Lilly and Zula

ADDRESS

403 E. W. 1st

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85376

CERTIFICATE OF DEATH.

28 185376
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1436 Argyle Ave. ST. 14 WARD)

2-FULL NAME

Minnie Harris

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1436 Argyle Ave. St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F

4-COLOR OR RACE,

Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

1896
(Year)

7-AGE

29

— yrs., — mos., — ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic

9-BIRTHPLACE, (State or Country),

Md

10-NAME OF FATHER,

Frank Hall

11-BIRTHPLACE OF FATHER (State or Country),

Ma.

12-MAIDEN NAME OF MOTHER

Mary E. Bell

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Bell

(Address) 1436 Argyle Ave.

15-

MAY 17 1915

HARRY O. ARKLEWS,

101st Annual Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 14, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 10 1915, to May 14 1915, that I saw him alive on May 13 1915, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) D. G. Williams, M. D.

May 15 1915 (Address) 708 E. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn Cemetery

DATE OF BURIAL,

May 16 1915

20-UNDERTAKER

Holt & Elliott

ADDRESS

508 B. 70th

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85377

C85377

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *638 Sterling*ST. *10*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME

(Residence in Baltimore: No. *638 Sterling*

St.: — yrs. — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored

5-SINGLE,

Single

MARRIED,

WIDOW,

OR DIVORCED.

(Write the word.)

6-DATE OF BIRTH.

None known

(Month)

(Day)

(Year)

7-AGE.

22

yrs.

mos.

da.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*House Keeper
Private Family*

9-BIRTHPLACE.

(State or Country).

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

*Maryland
Geo A. Young
Md.
Sarah A. Ringgold
Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo A. Young*(Address) *638 Sterling St*

MAY 17 1915.

Filed

191

Baptist

Formal

Clerk

S

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 14

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 11 191*5*, to *May 14* 191*5*,that I saw him alive on *May 14* 191*5*,and that death occurred, on the date stated above, at *9:25 P.M.*

The CAUSE OF DEATH* was as follows:

*Pyo-Salpingitis**10 days* (Duration) *10* yrs. *10* mos. *10* da.CONTRIBUTORY (Secondary) *Left Sup. Peritonitis**4 days* (Duration) *10* yrs. *10* mos. *10* da.(Signed) *W. Edward Fisher, M.D.**May 15* 191*5* (Address) *1612 E. Monument*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

*Laurel Cemetery*20-UNDERTAKER *Robert A. Elliott*DATE OF BURIAL *May 18* 191*5*ADDRESS *26 Hayes Cir*

important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85378 HEALTH DEPARTMENT--CITY OF BALTIMORE C85378

CERTIFICATE OF DEATH

PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hsp* ST. *10* WARD)
FULL NAME *Thomas Chambers*
(Residence in Baltimore: No. *838 McKim St.* St. *—* yrs. *—* mos. *—* ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and RH out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX *male* COLOR OR RACE *Black* SINGLE *Single*
DATE OF BIRTH *July 16, 1896*
AGE *28* yrs. *9* mos. *29* ds. or *1* day, *—* hrs., *—* min.?
OCCUPATION (a) Trade, profession or particular kind of work *Teamster*
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country) *md*
PARENTS
10-NAME OF FATHER *Thos. Chambers*
11-BIRTHPLACE OF FATHER (State or country) *md*
12-MAIDEN NAME OF MOTHER *Anna Wilson*
13-BIRTHPLACE OF MOTHER (State or country) *md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Johns Hopkins Hsp*
(Address) *Johns Hopkins Hsp*

MAY 17 1915
Filed 191

HARRY C. ANDREWS,
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *May 15, 1915*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *May 13, 1915*, to *May 12, 1915*,
that I saw him alive on *May 13, 1915*,
and that death occurred, on the date stated above, at *11:30* a.m.
The CAUSE OF DEATH* was as follows:

Heart Block
(Stokes - Adams Disease)

(Duration) yrs. *1* mos. *—* ds.

Contributory (SECONDARY)

(Duration) yrs. *—* mos. *—* ds.

(Signed) *Staphors Bayne Jones* M.D.
May 15, 1915 U. [Address] *Johns Hopkins Hospital*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. *2* in the *18* mos. *9* ds. State *md*

Where was disease contracted, if not at place of death?

Former or usual residence *838 McKim St.*

16-PLACE OF BURIAL OR REMOVAL

Mt. Zion Cemetery
UNDERTAKER *Robert A. Elliott*

DATE OF BURIAL

May 18, 1915
ADDRESS *306 Regis*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85379 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

189 REGISTERED NO. C

C85379

PLACE OF DEATH

CITY OF BALTIMORE (NO.

1135 Columbia Ave ST. 21

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Thomas Ireland Elliott

(Residence in Baltimore: No.

1135 Columbia Ave

St.; yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

Jan.

1st, 1915

7-AGE,

4 yrs. 4 mos. 14 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE, (State or Country),

Md. Balt City

10-NAME OF FATHER,

David Elliott

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Rosie Hofheim

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

David Elliott

(Address)

1135 Columbia Ave

15-

MAY 17 1915

HARRY C. ATHERTON,

Sanitary Permit Clerk

5

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

15

1915

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Unknown Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

May 16, 1915 (Address) 2302 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cem.

DATE OF BURIAL,

May 17, 1915

20-UNDERTAKER

Joseph B Cook

ADDRESS

1003 N. Calhoun St

C85380

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85380

CERTIFICATE OF DEATH

REGISTERED NO. C. 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109)

WARD 7

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 13.)

2-FULL NAME

(Residence in Baltimore: No. 109)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Unknown, 1 -

7-AGE

25?

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Cook

9-BIRTHPLACE
(State or country)

Tenn.

10-NAME OF FATHER

Charles Allison

11-BIRTHPLACE OF FATHER
(State or country)

Tenn.

12-MAIDEN NAME OF MOTHER

Martha Greenlee

13-BIRTHPLACE OF MOTHER
(State or country)

N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. Curry
C. H. H. H.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 14, 1915

17- I HEREBY CERTIFY, That I attended deceased from

May 5, 1915, to May 14, 1915,

that I saw her alive on May 14, 1915,

and that death occurred, on the date stated above, at 8:22 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

Contributory
(SECONDARY)operation for myoma
uteri

(Signed)

George W. Camer

May 17, 1915 [Address] J. H. H. H.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. 9 ds. State yrs. mos. 9 ds.

Where was disease contracted, If not at place of death?

Former or usual residence Royster Bldg Norfolk Va

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jonesboro Tenn

May 17, 1915

20-UNDERTAKER

Albert E. Fuller

ADDRESS

221 N. Broadway

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 17 1915

Filed

191

HENRY O. ANDREWS,
Sanial Permit Clerk
REGISTRAR

C85381

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 C85381

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1227 Valley*ST.; *10* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Henry F. Schaefer*(Residence in Baltimore: No. *1227 Valley*St.; *50* yrs., .. mos. .. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *married*

6-DATE OF BIRTH,

*Apr**29*, *1861*

(Month)

(Day)

(Year)

7-AGE,

44 yrs. .. mos. .. da.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *leaf printer*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).*Germany*

10-NAME OF FATHER,

*John Schaefer*11-BIRTHPLACE OF FATHER
(State or Country).*Germany*

12-MAIDEN NAME OF MOTHER

*not known*13-BIRTHPLACE OF MOTHER
(State or Country).*not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Mary Schaefer*(Address) *1227 Valley St.*

15-

MAY 17 1915

Filed

191

HARRY O. ANDREWS,

Baptist Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May**14**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Apr 23**1915*, to *May 14**1915*

,

*1915*that I saw him alive on *May 14**1915*

,

1915

,

*1915*and that death occurred, on the date stated above, at *11 P.* m.

The CAUSE OF DEATH* was as follows:

*Endocarditis**following Acute Rheumatism*(Duration) .. yrs. .. mos. .. da. *22*CONTRIBUTORY *Hypertensive pneumonia*
(Secondary)(Duration) .. yrs. .. mos. .. da. *5*(Signed) *J. M. C. Parker* M. D.*May 15* 1915 (Address) *1051 Crescent*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .. yrs. .. mos. .. ds. In the .. State .. yrs. .. mos. .. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Cemetery

DATE OF BURIAL,

May 18, 1915

20-UNDERTAKER

Henry Brock Sen

ADDRESS

1301 E. Bay St.

important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85382

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85382

CERTIFICATE OF DEATH
1. PLACE OF DEATH *The Shelter for Aged Colored Women*
CITY OF BALTIMORE (No. *517 W Biddle* St. *17* WARD)
2. FULL NAME *Lucy Perkins*
Residence in Baltimore: No. *517 W Biddle St* St. *22* yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Colored* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*
6. DATE OF BIRTH *Unknown*, 18*28*
(Month) (Day) (Year)
7. AGE *87* yrs. — mos. — ds. If LESS than 1 day, — hrs. or — min.?
8. OCCUPATION (a) Trade, profession, or particular kind of work *Domestic*
(b) General nature of industry, business, or establishment in which employed (or employer) *Cook*
9. BIRTHPLACE (State or country) *Kent Co. Md.*

PARENTS

10. NAME OF FATHER *Don't know*
11. BIRTHPLACE OF FATHER (State or country) *Don't know*
12. MAIDEN NAME OF MOTHER *Don't know*
13. BIRTHPLACE OF MOTHER (State or country) *Don't know*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

MAY 17 1915

LARRY O. ANDREWS,
Burial Permit Officer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 16*, 191*5*
(Month) (Day) (Year)
17. I HEREBY CERTIFY That I attended deceased from *May 1*, 191*5*, to *May 13*, 191*5*, that I saw her alive on *May 13*, 191*5*, and that death occurred, on the date stated above, at *5 P* m. The CAUSE OF DEATH* was as follows:
Renal Insufficiency
(Duration) *6* yrs. — mos. — ds.

Contributory (SECONDARY)

(Signed) *Shubert Stucumbe* M. D.
May 17, 191*5* (Address) *1316 N Charles St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *22* yrs. — mos. — ds. In the *87* yrs. — mos. — ds.
Where was disease contracted *The Shelter for Aged Colored Women*
If not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Laurel Cem.

DATE OF BURIAL

May 18, 191*5*

20. UNDERTAKER

Chas E Branch

ADDRESS

802 Madison Ave

C85383

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 C85383

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 N. Rutland Ave ST.: 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1505 N. Rutland Ave St.; 8 yrs., 11 mos., 16 ds.)Margaret A. Baer

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH

May 29th, 1879
(Month) (Day) (Year)

7-AGE

35 yrs., 11 mos., 16 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Housewife

9-BIRTHPLACE, (State or Country),

Md

10-NAME OF FATHER

John Miller

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Catherine Remmers

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm B. Baer(Address) 1505 N. Rutland Ave

15-

Filed

MAY 17 1915ROBERT K. KRAUTERSerial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 15th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Feb 20 1915, to May 15 1915, that I saw her alive on May 15 1915, and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration).....yrs.....mos.5 ds.

CONTRIBUTORY (Secondary)

(Signed) John T. Spickard M. D.
May 17, 1915. (Address) 2112 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore

DATE OF BURIAL

May 18 1915

20-UNDERTAKER

Philip Herwig

ADDRESS

2016 Orleans

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85384

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85384

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital,
CITY OF BALTIMORE (No. Linden ave. & Madison st. ST. 13 WARD)

REGISTERED NO. C

2-FULL NAME Mary Ann Keller,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2956 Cedar avenue.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married,

6-DATE OF BIRTH, May 10th, 1866. (Month) (Day) (Year)

7-AGE, 49 yrs., 0 mos., 5 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housewife, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Pennsylvania,

10-NAME OF FATHER, ? Daub,

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania,

12-MAIDEN NAME OF MOTHER, Unknown,

13-BIRTHPLACE OF MOTHER (State or Country), Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Keller, daughter,

(Address) 2956 Cedar avenue.

15- MAY 17 1915 ROBERT KRAUTER, Registrar.

Filed 1915

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Campbell, M. D. (Coroner.)

May 15th 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Golden Park

DATE OF BURIAL, May 17, 1915

20-UNDERTAKER, J. S. Marshall

ADDRESS, 3539 Hill Rd

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85385

CERTIFICATE OF DEATH

28 40

C85385

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 3603 Falls Road

ST. 13 WARD)

2-FULL NAME Ida M. Boblits

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)

(Residence in Baltimore: No. 3603 Falls Road St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female	4-COLOR OR RACE White	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
6-DATE OF BIRTH July 7 1870 (Month) (Day) (Year)		
7-AGE 44 10 8 yrs. mos. ds. or min.? If LESS than 1 day, hrs.		
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Merchant		
9-BIRTHPLACE (State or country) Md.		

PARENTS

10-NAME OF FATHER Michael Boblits	11-BIRTHPLACE OF FATHER (State or country) Balto. Co. Md.
12-MAIDEN NAME OF MOTHER Percilla Royston	13-BIRTHPLACE OF MOTHER (State or country) Balto. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss. Emma Boblits

(Address) 3603 Falls Road

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
May 15 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from February 1915 to May 15th 1915, that I saw her alive on May 15th 1915, and that death occurred, on the date stated above, at 10 P. m. The CAUSE OF DEATH* was as follows:

Chronic Catarrhal Bronchitis with Gastritis as a Complication
Previously Tubercular (Duration) yrs. mos. ds.
Contributory Chronic & laborious work
(Signed) Geo. H. Baerms M. D.
May 16, 1915 [Address] 212 25th St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL
St. Mary's Hampden
DATE OF BURIAL
May 18 1915

20-UNDERTAKER
A. S. Marshall 3539 Falls Road
ADDRESS

18- MAY 17 1915

ROBERT . KRAUTER,
Burial Permit Clerk
REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85386

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85386

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. *309 Lakewood Ave* ST. *6* WARD)

2-FULL NAME *James P. Neary*

(If death occurred in a hospital or institution, give its NAME instead of street and number and room No. 12.)

(Residence in Baltimore: No. *309 Lakewood Ave* St.; *60* yrs. *0* mos. *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Widowed*

6-DATE OF BIRTH *Jan 25th 1895*
(Month) (Day) (Year)

7-AGE *60* yrs. *3* mos. *20* ds. or min. *1* day, *0* hrs. *0* min. If LESS than 1 day, hrs. min.?

8-OCCUPATION (a) Trade, profession or particular kind of work *Watchman* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Ind.*

10-NAME OF FATHER *Thomas Neary*

11-BIRTHPLACE OF FATHER (State or country) *Ireland*

12-MAIDEN NAME OF MOTHER *Don't know*

13-BIRTHPLACE OF MOTHER (State or country) *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Margaret Neary*

(Address) *309 Lakewood*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 15th 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 9th 1915*, to, *May 15th 1915*, that I saw him alive on *May 15th 1915*, and that death occurred, on the date stated above, at *2:30 P.M.* The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Contributory (SECONDARY) *Neurisy* (Duration) yrs. mos. ds. *8* ds.

(Signed) *Adam A. Ford* M.D. *May 17 1915* [Address] *3019 Eastern Ave*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Cathedral*

DATE OF BURIAL *May 18th 1915*

20-UNDERTAKER *John A. Moran*

ADDRESS *Camden*

18 MAY 17 1915

ROBERT . KRAUTER,

Burial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85387

C85387

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1045 Chesquith ST. 10 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 1045 Chesquith St. St.: 49 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH.

Dec. 25, 1865
(Month) (Day) (Year)

7-AGE,

49 yrs. 4 mos. 25 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Merchant(b) General nature of industry, business, or establishment in which employed (or employer) Gents. furnishings

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

David Creamer

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Mary Love

13-BIRTHPLACE OF MOTHER (State or Country),

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Horace Creamer(Address) 1045 Chesquith St.

15-

MAY 17 1915

Filed

ROBERT KRAUTER

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 30 1915, to May 16 1915,that I saw him alive on May 16 1915,and that death occurred, on the date stated above, at 11:45 AM.

The CAUSE OF DEATH* was as follows:

LeucemiaLeucemia(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Russell M. D.May 16, 1915 (Address) 802 Chesquith St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenmount Cemetery May 17, 1915

20-UNDERTAKER

ADDRESS

Liston P. Fussellbaugh 2620 St. Paul St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85388

C85388

CERTIFICATE OF DEATH.

50 REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.; *9* WARD)2 FULL NAME *Vernie Chase*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. *503 E. 27th* St.; *unknown* yrs., *unknown* mos., *unknown* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *female*4-COLOR OR RACE, *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widow*6-DATE OF BIRTH, *August 15, 1857*

(Month)

(Day)

(Year)

7-AGE, *57* yrs., *9* mos., *—* ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Ireland*10-NAME OF FATHER, *James McQuade*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER, *Bridget Carroll*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lottie E. Kirk*(Address) *503 E. 27th St.*

15

MAY 17 1915

ROBERT J. KRAUTER

Filed....., 191... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 14, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 11, 1915*, to *May 14, 1915*,that I saw her alive on *May 14, 1915*,and that death occurred, on the date stated above, at *12 P. m.*

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus(Duration) *unknown* yrs., *—* mos., *—* ds.CONTRIBUTORY (Secondary) *Diabetic Gangrene*(Duration) *5 weeks* yrs., *—* mos., *—* ds.(Signed) *J. H. Vinton, Chief, M. D.**May 15, 1915* (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *—* mos. *3* ds. In the State yrs. *—* mos. *—* ds.Where was disease contracted, if not at place of death? *unknown*Former or usual residence *503 E. 27th St.*19-PLACE OF BURIAL OR REMOVAL, *Holy Cross*DATE OF BURIAL, *May 18, 1915*20-UNDERTAKER, *H. C. Widdifield*ADDRESS *914 Greenmount*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85389

CERTIFICATE OF DEATH.

REGISTERED NO. C

C85389

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *3* WARD)

2-FULL NAME

(Residence in Baltimore: No. *830 Granby St* St.; yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(If married, give the name of the spouse.)*Single*

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

31?

yrs. mos. da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Lab. Day*9-BIRTHPLACE,
(State or Country),*Md.*

10-NAME OF FATHER,

*Not known*11-BIRTHPLACE OF FATHER
(State or Country),*Not known*

12-MAIDEN NAME OF MOTHER

*Not known*13-BIRTHPLACE OF MOTHER
(State or Country),*Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Record Mercy Hosp.*(Address) *Calvert St.*

15-

MAY 17 1915 ROBERT . KRAUTER, Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 17, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 14, 1915, to *May 17, 1915*,that I saw him alive on *May 17, 1915*,and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

*Gastric Ulcer - Perforated**about* (Duration) yrs. mos. da.CONTRIBUTORY
(Secondary)*Equal Contribution*
(Duration) yrs. mos. da.(Signed) *Edward J. ...* M. D.*May 17, 1915* (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted if not at place of death? *830 Granby St*Former or usual residence *830 Granby St*

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislawas

DATE OF BURIAL,

May 20, 1915

20-UNDERTAKER

Jno. Publicanekas

ADDRESS

5008 Paca H.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85390

CERTIFICATE OF DEATH.

92 C85390

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 E Eager

ST.: 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Mallon (Mallon)

(Residence in Baltimore: No. 825 E Eager

St.: yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-STATUS, Married, Widowed, or Divorced. (Write the word.) Infant

6-DATE OF BIRTH, unknown, 1913. (Month) (Day) (Year)

7-AGE, 2 yrs. 11 mos. 11 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Baltimore City

10-NAME OF FATHER, John Mallon

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Mallon

(Address) 825 E. Eager St.

15- MAY 17 1915. ROBERT KRAUTER, Registrar.

Filed, 1915. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1915, to May 17 1915, that I saw her alive on May 17 1915, and that death occurred, on the date stated above, at 10 am.

The CAUSE OF DEATH* was as follows: Crampous Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(Signed) W. W. Pearce M. D. May 17 1915. (Address) 5 E. P. Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Cathedral Cemetery May 19, 1915.

20-UNDERTAKER, ADDRESS, Martin Fahy Sons 606 Lafayette Ave.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85391

CERTIFICATE OF DEATH

C85391

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3204 Baker)St.: 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. 3204 Baker

St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

married

6-DATE OF BIRTH.

..... Feb. 22, 1863
(Month) (Day) (Year)

7-AGE.

53 yrs. - mos. - ds.

IF LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

House Work

9-BIRTHPLACE.
(State or Country).

Baltimore

PARENTS.

10-NAME OF FATHER.

Joshua Vansant

11-BIRTHPLACE OF FATHER
(State or Country).

Holland

12-MAIDEN NAME OF MOTHER

Anna Ross

13-BIRTHPLACE OF MOTHER
(State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Charles H. Britzell

(Address).....

1228 S. Charles St.

15-

MAY 17 1915

ROBERT J. KRAUTER,

Filed....., by..... Burial Permit.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 17, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from
May 1-1915, to May 17, 1915,
that I saw him alive on May 16, 1915,
and that death occurred, on the date stated above, at 7:00 am.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum
(Chronic Diarrhea)CONTRIBUTORY
(Secondary)

(Signed)..... M. D.

May 17, 1915. (Address) 1228 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence.....

20-PLACE OF BURIAL OR REMOVAL.

Mt Olivet Cem

DATE OF BURIAL.

May 17, 1915.

21-UNDERTAKER

William Cook

ADDRESS

502 E. North

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

085392

CERTIFICATE OF DEATH.

79 085392
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, No.

648 Cokesbury Ave. ST. 9 WARD

2-FULL NAME

Elizabeth Harkins (Harkins)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

648 Cokesbury Ave.

St. yrs. 3 mos. dn)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widow

6-DATE OF BIRTH.

Dec 3rd, 1841
(Month) (Day) (Year)

7-AGE.

73 yrs. 5 mos. 14 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE, (State or Country).

Pennsylvania

PARENTS.

10-NAME OF FATHER.

Daniel Small

11-BIRTHPLACE OF FATHER (State or Country).

Pennsylvania

12-MAIDEN NAME OF MOTHER

Do not know

13-BIRTHPLACE OF MOTHER (State or Country).

Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs B. Myers

(Address)

648 Cokesbury Ave.

15-

MAY 17 1915

ROBERT F. KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH.

May 17, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 1, 1915, to May 17, 1915, that I saw her alive on May 17, 1915, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Lee Magness M. D.

May 17, 1915 (Address) 1206 E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

York pa

DATE OF BURIAL.

May 20, 1915

20-UNDERTAKER

ADDRESS

C. R. Zeatrick 2433 North Ave.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85393

CERTIFICATE OF DEATH.

28 C85393

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

713 N. Patterson Park Ave. St. 7

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Edwin F. Garrison

(Residence in Baltimore: No.

713 N. Patterson Park Ave.

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

January 21, 1883
(Month) (Day) (Year)

7-AGE,

32 yrs. 3 mos. 24 ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Coal Miner

(b) General nature of industry, business, or establishment in which employed (or employer).

Mortuary

9-BIRTHPLACE,

(State or Country),

Md

10-NAME OF FATHER,

Edwin F. Garrison Sr.

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Charlotte Curry

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theresa Garrison

(Address) 713 N. Patterson Park Ave.

15-

Filed

MAY 17 1915

ROBERT J. KRAUTER

MAY 17 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 15, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Feb 16 1913, to May 15 1915,
that I saw him alive on May 15 1915,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary tuberculosis

(Duration) yrs. mos. ds.

(Signed)

Edwin F. Garrison M. D.

May 17, 1915 (Address) 713 N. Patterson Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oak Lawn Cemetery

May 17, 1915

20-UNDERTAKER

ADDRESS

Christian Miller

2535 Jefferson

important. See instructions on back of certificate.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Margaret Cuzemann
HEALTH DEPARTMENT--CITY OF BALTIMORE

685394

45 685394

CERTIFICATE OF DEATH

1-PLACE OF DEATH *Hebrew Hospital*
CITY OF BALTIMORE: (No. *Monument & Rutledge* ST. *6* WARD)
2-FULL NAME *Mrs. Margaret Cuzemann*
(Residence in Baltimore: No. *406 N. Bethel* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and add out No. 12.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE MARRIED WIDOWED OR DIVORCED *Widow* (Write the word)
6-DATE OF BIRTH *January 22*, 1857 (Month) (Day) (Year)
7-AGE *64* yrs. *3* mos. *22* ds. or min.?
8-OCCUPATION (a) Trade, profession or particular kind of work *House work* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Md

PARENTS

10-NAME OF FATHER *Stephen Kramer*
11-BIRTHPLACE OF FATHER (State or country) *Germany*
12-MAIDEN NAME OF MOTHER *Barbara Wankmiller*
13-BIRTHPLACE OF MOTHER (State or country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Anna Wiefelbach*
(Address) *405 N. Bethel St*

15- MAY 17 1915 ROBERT . KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 16*, 1915 (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I attended deceased from *May 13*, 1915, to, *May 16*, 1915, that I saw her alive on *May 16*, 1915, and that death occurred, on the date stated above, at *1:44* pm.
The CAUSE OF DEATH* was as follows:

Carcinoma of gall bladder
(Clinical Diagnosis)

(Duration) ? yrs. mos. ds.
Contributory (SECONDARY) *Perforation of stomach*
Intoxication (Duration) yrs. mos. ds.
(Signed) *M. B. Levine* M. D.
5-16, 1915 (Address) *Hebrew Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *2* yrs. *2* mos. *2* ds. State *2* yrs. *2* mos. *2* ds.
Where was disease contracted, If not at place of death? *Unknown*
Former or usual residence *405 N. Bethel*

19-PLACE OF BURIAL OR REMOVAL *5th Reform Cemetery* DATE OF BURIAL *May 19/15*
20-UNDERTAKER *Christian Miller* ADDRESS *233 N. Jefferson*

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85395

CERTIFICATE OF DEATH

28 C85395

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 N. Bond.

ST.

WARD

2-FULL NAME John V. Mc-Lain,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1125 N. Bond. St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widower

6-DATE OF BIRTH

October 27

1892

(Month)

(Day)

(Year)

7-AGE

72

6

19

If LESS than

1 day, hrs.

min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Machinist

9-BIRTHPLACE

(State or country)

Maryland

10-NAME OF FATHER

Robert Mc-Lain

11-BIRTHPLACE OF FATHER

(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Sarah Summers

13-BIRTHPLACE OF MOTHER

(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Robert Mc-Lain
1125 N. Bond St.

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

May 16 1915.

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I have seen deceased from March 23 1915 to May 16 1915

that I saw him alive on May 15 1915

and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis.

Contributory (SECONDARY)

(Signed)

May 16 1915.

Address 936 E. Monument St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore County May 18 1915.

20-UNDERTAKER

ADDRESS 2433

Chas. Fitzpatrick W. North Ave.

15-

MAY 17 1915

ROBERT J. KRAUTER

Burial Permit Clerk

REGISTRAR

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85396

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

151 C85396
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 N Sterling St. ST. 10 WARD)

2-FULL NAME Giuseppe Martonilo

(Residence in Baltimore: No. 922 N Sterling St. St.; yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE MARRIED Widowed or Divorced (Write the word) Infant

6-DATE OF BIRTH April 16, 1915 (Month) (Day) (Year)

7-AGE 22 yrs. 1 day, 1 hrs., 1 min. 11 LESS than

8-OCCUPATION (a) Trade, profession or particular kind of work Infant. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore Md.

10-NAME OF FATHER Agostina Martonilo

11-BIRTHPLACE OF FATHER Italy

12-MAIDEN NAME OF MOTHER Cletha Satti

13-BIRTHPLACE OF MOTHER Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agostina Martonilo (Address) 922 N Sterling St.

15- MAY 17 1915 ROBERT J. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 17, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 11, 1915, to May 17, 1915, that I saw him alive on May 16, 1915, and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. mos. 22 ds.

Contributory (SECONDARY) Unknown

(Duration) yrs. mos. ds.

(Signed) Robt J. Green M. D.

May 17, 1915, [Address] 120 1/2 Paiswick St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Vincent Cem May 15, 1915

20-UNDERTAKER ADDRESS

Wendell Shippey 372 E. Ave. St.

C85397

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 C85397

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1171)

ST. 2

WARD

2-FULL NAME

(Residence in Baltimore: No. 1171)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Single

6-DATE OF BIRTH,

May 13th, 1915

(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,

yrs. mos. 1 ds.

hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

Baltimore Md.

10-NAME OF FATHER,

Jm Buecher

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Lolita Myworth

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lollie Buecher

(Address) 1171 Hamberg St.

15-

MAY 18 1915.

Filed

191

HARRY O. ATLANT

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 14, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 13 1915, to May 14 1915

that I saw him alive on May 13 1915

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
6 months pregnancy
(Duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) S. Shepherd M. D.

May 14 1915 (Address) 1227 Columbia St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Linden Park

DATE OF BURIAL,

May 18 1915

20-UNDERTAKER

John Stewart & Son 901 Hallway

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85398

CERTIFICATE OF DEATH.

67 C85398

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1407 E. Fayette St* ST. *5* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Abraham Patz (Patz)*(Residence in Baltimore: No. *1407 E. Fayette St* St.; *28* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH

Unknown, *1843*
(Month) (Day) (Year)

7-AGE

72 yrs. mos. da. *IF LESS than 1 day,*
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Retired*9-BIRTHPLACE,
(State or Country),*Russid*

10-NAME OF FATHER,

*Abraham Patz*11-BIRTHPLACE OF FATHER
(State or Country),*Russid*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Russid*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Leurs*(Address) *1419 E. Balto St*

15-

MAY 18 1915 HARRY O. ANDREWS,
Filed *191* Serial *Permit to O.L.R.*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5, *17*, *1915*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *July 6* 1914, to *May 17* 1915, that I saw him alive on *May 17* 1915, and that death occurred, on the date stated above, at *6:30 P.* m.

The CAUSE OF DEATH* was as follows:

Parasit(Duration) *2* yrs. mos. da.

CONTRIBUTORY (Secondary)

Old age & Refusal to take medicine (Duration) *7* yrs. mos. da.(Signed) *E. C. Green* M. D.*May 17, 1915* (Address) *275 August*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. mos. da. In the State ... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Hebron Hill Burial

DATE OF BURIAL,

May 18, 1915

20-UNDERTAKER

Jack Leurs

ADDRESS

1419 E. Balto St

important. See instructions on back of certificate.

C85400

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41

C85400

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1341 N. Gay St., ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Klein.

(Residence in Baltimore: No. 1341 N. Gay St., St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, June 26, 1857.
(Month) (Day) (Year)

7-AGE, 57 yrs., 10 mos., 20 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, House work
(b) General nature of industry, business, or establishment in which employed (or employer), at home

9-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER, Not known
11-BIRTHPLACE OF FATHER (State or Country), Not known
12-MAIDEN NAME OF MOTHER, Not known
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....Henry G. Klein,.....

(Address).....1341 N. Gay St.,.....

15-

FILED MAY 18 1915 HARRY O. ANDREWS,
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 16, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 10, 1915, to May 16, 1915, that I saw her alive on May 15, 1915, and that death occurred, on the date stated above, at 10 A. m. The CAUSE OF DEATH* was as follows:

Caecum of sigmoid
Operation for relief
(Duration) yrs. 9 mos. ds.

CONTRIBUTORY Toxemia & E. Coli
(Secondary)

(Duration) yrs. 3 mos. ds.
(Signed) Harry G. Klein, M. D.
May 17, 1915 (Address) 120 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Baltimore May 19, 1915.

20-UNDERTAKER ADDRESS

Sander & Sons 1700 S. Mount St.

C85401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *609 S. Becker ave* ST. *14* WARD)2-FULL NAME *Lucie V. Waller*(Residence in Baltimore: No. *609 S. Becker ave* St. *14* yrs. *17* mos. *17* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)6-DATE OF BIRTH, *June 17*, 1915 (Month) (Day) (Year)7-AGE, *4* yrs. *4* mos. *17* ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Balto City*10-NAME OF FATHER, *Tilden T. Waller*11-BIRTHPLACE OF FATHER (State or Country), *Balto City*12-MAIDEN NAME OF MOTHER *Edna Weston*13-BIRTHPLACE OF MOTHER (State or Country), *Balto City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Tilden T. Waller*(Address) *609 S. Becker ave*

15- MAY 18 1915 HARRY O. ANDREWS,

Filed....., 1915. Serial Permit. *4122* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 17*, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 15* 1915, to *May 17* 1915, that I saw her alive on *May 15* 1915, and that death occurred, on the date stated above, at *11:30* m. The CAUSE OF DEATH* was as follows:*Enteritis*
(Duration).....yrs.....mos.....ds.CONTRIBUTORY.....*Exhaustion*
(Secondary)(Signed).....*C. L. Lane*.....M. D.
5/17, 1915. (Address) *2701 Eastern*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Clark Lawn*DATE OF BURIAL, *May 19*, 191520-UNDERTAKER *H. Sander & Sons*ADDRESS *1710 Clutts*

Important. See instructions on back of certificate.

C85402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85402

PLACE OF DEATH

CITY OF BALTIMORE (No. *607 S. Belhel*)

ST.:

WARD)

REGISTERED NO. C.

2-FULL NAME

John Feldmann

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *607 S. Belhel*)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

June 17, 1853
(Month) (Day) (Year)

7-AGE,

61 yrs. 11 mos. ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Huckster*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*John Feldmann*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Maria Osterhurs*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Foster

(Address)

Washington St.

15-

Filed

*MAY 18 1915**HARRY O. ADAMS,**Registrar.*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 17, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*
(Inquest, au-*inquest* and that said deceased came to *his* death
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. Jones M. D.
(Coroner)*May 17, 1915* (Address) *3116 Dixon St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Carmel

DATE OF BURIAL,

May 18, 1915

20-UNDERTAKER

ADDRESS

H. Sander & Sons 1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

State CAUSE OF DEATH in main terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85403

CERTIFICATE OF DEATH

C85403

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *1122 N. Milton Ave* ST. *8* WARD)

2-FULL NAME

Dorothy J. Prim

(Residence in Baltimore: No. *1122 N. Milton Ave* St.; *8* yrs. *5* mos. *3* ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and file inst No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX <i>Female</i>	4-COLOR OR RACE <i>White</i>	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>Single</i>
6-DATE OF BIRTH <i>Sept. 11, 1899</i> (Month) (Day) (Year)	7-AGE <i>15</i> yrs. <i>5</i> mos. <i>3</i> ds. or min.?	
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <i>School Girl</i>		
9-BIRTHPLACE (State or country) <i>Sumner Co. Md</i>		
10-NAME OF FATHER <i>J. C. Prim</i>		
11-BIRTHPLACE OF FATHER (State or country) <i>England</i>		
12-MAIDEN NAME OF MOTHER <i>Mrs. Harford</i>		
13-BIRTHPLACE OF MOTHER (State or country) <i>England</i>		

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. J. Prim*

(Address) *1122 N. Milton Ave*

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *May 14, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Apr 1913*, to *May 14, 1915*, that I saw her alive on *May 10, 1915*, and that death occurred, on the date stated above, at *1:30 p.m.*

The CAUSE OF DEATH was as follows:

Mitral Insufficiency
3

Contributory (SECONDARY)

(Signed) *H. J. Powers* M. D.
May 16, 1915 (Address) *257 E. Canton*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Carmel C.

May 18, 1915

20-UNDERTAKER

ADDRESS

Geo M. Fink 812 N. Wolfe

MAY 18 1915

Filed..... 191

DEPT. OF HEALTH, BALTIMORE
Burial Permit No. *1122 N. Milton Ave*

REGISTRAR

C85404

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85404

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *#8 W Fort Ave*
 CITY OF BALTIMORE: (No. *23* ST. *23* WARD)
 2-FULL NAME *Anton Siebert*
 (Residence in Baltimore: No. *#8 W. Fort Ave* St. *55* yrs. *5* mos. *5* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*
 6-DATE OF BIRTH, *May 9th, 1847*
 (Month) (Day) (Year)
 7-AGE, *68* yrs. *7* mos. *7* ds. If LESS than 1 day, hrs. or min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Labourer*
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Germany*
 10-NAME OF FATHER, *Ferdinand Siebert*
 11-BIRTHPLACE OF FATHER, (State or Country), *Germany*
 12-MAIDEN NAME OF MOTHER, *Not known*
 13-BIRTHPLACE OF MOTHER, (State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *George Siebert*
 (Address) *#8 W. Fort Ave*

15- *MAY 18 1915* HARRY O. ANDREWS,
 Filed..... 1915 *Marital Permit* Clerk
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 16th, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 10* 1915, to *May 16* 1915, that I saw him alive on *May 16* 1915, and that death occurred, on the date stated above, at *5:50 A* m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
 (Duration)..... yrs..... mos..... ds.
 CONTRIBUTORY (Secondary) *Arteriosclerosis*
 (Duration)..... yrs..... mos..... ds.
 (Signed) *W. H. Hammel* M. D.
 (Address) *101 E. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Holy Cross C.C.* DATE OF BURIAL, *May 19, 1915*
 20-UNDERTAKER, *E. & B. Harle* ADDRESS, *115 E. Head St.*

important. See instructions on back of certificate.

C85405

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 C85405

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infirmary* ST. 14 WARD)

REGISTERED NO. C

2-FULL NAME

Julia Paul

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Vincent's Infirmary* St.;

yrs. 3 mos. 5 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH,

January 11th, 1915
(Month) (Day) (Year)

7-AGE,

4 mos. 5 da.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country).*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country).*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country).*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

MAY 18 1915

DEPT. OF HEALTH

Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 16th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 1st* 1915, to *May 16th* 1915, that I saw her alive on *May 16th* 1915, and that death occurred, on the date stated above, at 1.50 P. M.

The CAUSE OF DEATH* was as follows:

Malnutrition & Malassimilation(Duration) *3 mos. 5 da.*CONTRIBUTORY
(Secondary)(Duration) *3 mos. 5 da.*(Signed) *Elmer G. Hall* M. D.
May 17, 1915 (Address) *1617 E. North Ave*

(State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. 5 da. In the State yrs. 4 mos. 5 da.

Where was disease contracted, if not at place of death *St. Vincent's Infirmary*Former or usual residence *St. Vincent's Infirmary*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Cathedral Cemetery *May 17, 1915*

20-UNDERTAKER

ADDRESS

Martin Fahey *106 Lafayette Ave*

important. See instructions on back of certificate.

C85406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 C85406
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.; *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; *1* yrs., *3* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH,

January 15, 1914
(Month) (Day) (Year)

7-AGE,

1 yrs., *4* mos., ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

MAY 18 1915

ESTER O. ADAMS,

Filed.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 15, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 12* 1915, to *May 14* 1915, that I saw him alive on *May 14* 1915, and that death occurred, on the date stated above, at *5:00* a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) ... yrs. ... mos. *2* ds.

CONTRIBUTORY (Secondary)

(Signed) *Elmer G. Hall* M. D.
May 16, 1915 (Address) *1617 E. North Ave.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *3* mos. ds. In the State *1* yrs. *4* mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

St. Vincent's Inf. Asylum

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral Cem.**May 19, 1915*

20-UNDERTAKER

ADDRESS

Martin Pakey & Son 606 La Fayette Ave

Important. See instructions on back of certificate.

C85407

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85407

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1436 Belvedere* ST.; *12* WARD)

3-FULL NAME

(Residence in Baltimore: No. *1436 Belvedere* St.; — yrs. — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Unknown 1864
(Month) (Day) (Year)

7-AGE,

51 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Danister*

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Connie E. Percy*(Address) *1436 Belvedere St.*

15-

MAY 18 1915

HARRY O. ANDREWS,

Filed

191

Baltimore Health Department Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 *16*, 191*5*.
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *May 15* 191*5*, to *May 16* 191*5*, that I saw him alive on *May 16* 191*5*, and that death occurred, on the date stated above, at *8:30* a.m.

The CAUSE OF DEATH was as follows:

Apoplexy

CONTRIBUTORY (Secondary)

(Duration) *7* yrs. — mos. — ds.(Signed) *R. Garland Russell* M. D.*May 17*, 191*5*. (Address) *424 E 23 St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Laurel Cemetery**May 17*, 191*5*.

20-UNDERTAKER

ADDRESS

*Geo. H. Holland**Robert St.*

important. See instructions on back of certificate.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

685408

685408

CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8)

610 Brice

ST.

16

WARD)

2-FULL NAME

Gladys J. Armiger

(Residence in Baltimore: No.

610 Brice

St.;

yrs.

mos.

21 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE white 5-SINGLE MARRIED WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH Oct 25, 1905 (Month) (Day) (Year)

7-AGE 9 yrs. 6 mos. 21 ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Scholl girl

9-BIRTHPLACE (State or country) Baltimore

10-NAME OF FATHER Thomas A Armiger Jr

11-BIRTHPLACE OF FATHER (State or country) Balto

12-MAIDEN NAME OF MOTHER Theresia A Gavin

13-BIRTHPLACE OF MOTHER (State or country) Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas A Armiger

(Address)

610 Brice St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 16, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 7, 1915, to May 16, 1915, that I saw her alive on May 15, 1915, and that death occurred, on the date stated above, at 10:15 P.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Contributory (SECONDARY) Rheumatism (Duration) 1 yrs. mos. ds.

(Signed) Geo. B. Shannon M. D. May 17, 1915 [Address] 700 Fulton Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

May 19, 1915

20-UNDERTAKER

William Cook

ADDRESS

...

18- MAY 18 1915

HARRY O. ADAMS,

REGISTRAR

C85409

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85409

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1550 W. Mulberry St.* ST. *20* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1550 W. Mulberry St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widow*

6-DATE OF BIRTH,

Dec 7th, 1883
(Month) (Day) (Year)

7-AGE,

61 yrs., 6 mos., 9 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*

9-BIRTHPLACE, (State or Country),

Ind

10-NAME OF FATHER,

Michael Hake

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Joseph Gehring*(Address) *1247 Riverside Ave*

MAY 18 1915

HARRY O. ANDREWS,

Filed..... 1915..

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 10th, 1915, to May 16th, 1915,
that I saw her alive on *May 16th, 1915,*and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH* was as follows:

Decaying Cerebral Haemorrhage(Duration) *4* yrs. *4* mos. *4* ds.CONTRIBUTORY (Secondary) *Heart Failure*(Duration) *4* yrs. *4* mos. *4* ds.(Signed) *H. H. Hayden* M. D.*May 15, 1915* (Address) *1428 Light St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *4* yrs. *4* mos. *4* ds. In the *4* yrs. *4* mos. *4* ds. State *4* yrs. *4* mos. *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Cem

DATE OF BURIAL,

May 19, 1915

20-UNDEERTAKER

Lily G. Ziehl

ADDRESS

4038 Rogers

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85410

CERTIFICATE OF DEATH.

151
C85410

PLACE OF DEATH

CITY OF BALTIMORE (No. 533 Oxford street, ST. 17 WARD)

FULL NAME Gertrude Jones,

(Residence in Baltimore: No. 533 Oxford street, St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, Single, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, April 6th, 1915, (Month) (Day) (Year)

7-AGE, 0 yrs., 1 mos., 7 ds., If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, William Jones,

11-BIRTHPLACE OF FATHER, (State or Country), Pennsylvania,

12-MAIDEN NAME OF MOTHER, Josephine Hayward,

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Josephine Jones, mother,

(Address) 533 Oxford street,

15-MAY 18 1915

Filed, 191. Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13th, 1915, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital debility and artificial feeding, (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) J. Frederick Campbell, M. D. (Coroner.)

May 14th 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, MAY 17 1915

20-UNDERTAKER, ADDRESS

FOR ANATOMICAL PURPOSES.

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85411

Bessie Sodie
HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH

C85411

104

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *7* WARD)

2-FULL NAME *Bessie Sodie*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RD out (No. 18.)

(Residence in Baltimore: No. *1534 E Monument* St. *1* yrs. *2* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX <i>Female</i>	4-COLOR OR RACE <i>white</i>	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>Child</i>
6-DATE OF BIRTH <i>February 18</i> 191 <i>5</i> (Month) (Day) (Year)		
7-AGE <i>1</i> yrs. <i>3</i> mos. ds. or min.? If LESS than 1 day, hrs., min.?		
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <i>Child</i>		
9-BIRTHPLACE (State or country) <i>Balt Md</i>		
PARENTS	10-NAME OF FATHER <i>Charles Sodie</i>	
	11-BIRTHPLACE OF FATHER (State or country) <i>Russia</i>	
	12-MAIDEN NAME OF MOTHER <i>Rose Winter</i>	
	13-BIRTHPLACE OF MOTHER (State or country) <i>Russia</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J Lewis*

(Address) *1419 E. Baltimore St*

15-
MAY 18 1915

HARRY O. ARLING,
Marial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 18 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 16* 191*5*, to, *May 18* 191*5*,
the I saw her alive on *May 18* 191*5*,
and that death occurred, on the date stated above, at *1 A* m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. *21* ds.
Contributory (SECONDARY) *Gastric Enteritis*
(Duration) yrs. mos. *2* ds.
(Signed), *M. B. Levin* M. D.
May 18 191*5*. [Address] *Hebrew Hosp*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. *2* ds. In the State... yrs. *3* mos. ds.

Where was disease contracted, if not at place of death? *1534 E Monument St*

Former or usual residence *Same*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Mt Carmel Rd *5/18* 191*5*

20-UNDERTAKER

ADDRESS

Jack Lewis *1419 E. Baltimore St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85412

C85412

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

818 W. North Ave. 13

ST. WARD)

2-FULL NAME

William Stewart Elmer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

818 W. North Avenue St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-MARRIED,

MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Nov. 2nd, 1840
(Month) (Day) (Year)

7-AGE,

74 yrs. 7 mos. 15 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*info of Visinger
H. Yeast*

9-BIRTHPLACE,

(State or Country),

N.J.

10-NAME OF FATHER,

Levio Elmer

11-BIRTHPLACE OF FATHER

(State or Country),

Pa.

12-MAIDEN NAME OF MOTHER

Mary Wickersham

13-BIRTHPLACE OF MOTHER

(State or Country),

in known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Elmer*(Address) *818 W. North Ave.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 17, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

1912, to *May 16 1915*that I saw him alive on *May 16 1915*and that death occurred, on the date stated above, at *9:15 A* m.

The CAUSE OF DEATH* was as follows:

*Cardio-renal disease**Gastric ulcer (chronic)**Chronic nephritis**severe*

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Cardio-vascular disease

(Duration) ... yrs. ... mos. ... ds.

(Signed)

Dr. R. A. Smith

M. D.

May 17, 1915 (Address) *1126 Collier St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

*Druid Ridge Cem**May 19, 1915*

20-UNDERTAKER

ADDRESS

E. M. Mite Lee & Co. 1201 W. Fayette

18-

MAY 18 1915

Filed

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85413

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85413

CERTIFICATE OF DEATH

x 28

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. *8*)

Johns Hopkins Hosp
Hugh R. Goforth

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and RH out No. 1D.)

(Residence in Baltimore: No. *13 W Main St Knoxville Tenn*)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

6-DATE OF BIRTH

Feb.
(Month)

28, 18*68*
(Day) (Year)

7-AGE

47 yrs.

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant

9-BIRTHPLACE

(State or country)

Tenn.

10-NAME OF FATHER

Napoleon Goforth

11-BIRTHPLACE OF FATHER

(State or country)

Tenn.

12-MAIDEN NAME OF MOTHER

Adeline Patterson

13-BIRTHPLACE OF MOTHER

(State or country)

Tenn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arclumy

(Address)

J. S. Hoop

15-

MAY 18 1915

REPORT . BRAUTER,

Sanitary Permit Officer

REGISTRAR

16-DATE OF DEATH

May, 18, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
Apr. 1, 1915, to *May 18*, 1915,

that I saw him alive on *May 18*, 1915,
and that death occurred, on the date stated above, at *5:30 p.m.*

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis
(Autopsy)

Contributory (SECONDARY)

Pulmonary Tuberculosis (Duration) yrs. mos. *21* ds.

(Signed)

J. Edward Burns M. D.
May 18, 1915 [Address] *244 Hoop*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. *47* ds. State... yrs. mos. *47* ds.

Where was disease contracted, If not at place of death?

Former or usual residence *13 W Main St Knoxville Tenn*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Knoxville Tenn *5.18*, 1915

20-UNDERTAKER

ADDRESS

Bojertons Sons Co *McCallister*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85414 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

6-DATE OF BIRTH *May 17, 1915* (Month) (Day) (Year)

7-AGE *1 yr. 11 mos. 18 ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *none* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Ba. Md.*

PARENTS 10-NAME OF FATHER *Edward Ruby* 11-BIRTHPLACE OF FATHER (State or country) *Ba. Md.* 12-MAIDEN NAME OF MOTHER *Matilda Ruby* 13-BIRTHPLACE OF MOTHER (State or country) *Ba. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Matilda Ruby* (Address) *2406 Orleans St.*

15. MAY 18 1915 ROBERT J. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 17, 1915* (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 17, 1915* to *May 17, 1915* that I saw him alive on *May 17, 1915* and that death occurred, on the date stated above, at *8:15 P.M.* The CAUSE OF DEATH* was as follows:

Premature birth 4 1/2 months (Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) *G. C. Deane* M.D. *5/18, 1915* (Address) *2600 E. Baltimore St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *London Park* DATE OF BURIAL *May 18, 1915*

20-UNDERTAKER *G. J. Walker* ADDRESS *723 W. 1st St.*

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85415

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

151

C85415

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *2406 Orleans* ST. *6* WARD)

FULL NAME *Edward Ruby Jr*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *2406 Orleans* St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word)

6. DATE OF BIRTH *May 17, 1915*
(Month) (Day) (Year)

7. AGE yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION *None*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country) *Ba H*

10. NAME OF FATHER *Edward Ruby*

11. BIRTHPLACE OF FATHER (State or country) *Ba H*

12. MAIDEN NAME OF MOTHER *Matilda Boone*

13. BIRTHPLACE OF MOTHER (State or country) *Ba H*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Matilda Boone*

(Address) *2406 Orleans*

15. *MAY 18 1915* *ROBERT . KRAUTER*

Filed *MAY 18 1915* *Permit Clerk*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10. DATE OF DEATH *May 17, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from *May 17, 1915* to *May 17, 1915*.
that I saw him alive on *May 17, 1915*.
and that death occurred, on the date stated above, at *11 1/2* m.
The CAUSE OF DEATH* was as follows:

Premature Birth
4 1/2 months
(Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) *A. O. Beaman* M. D.
5/18, 191*5* (Address) *2600 E. Pratt St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *London Park*

DATE OF BURIAL *May 18, 1915*

20. UNDERTAKER *G. J. Walker*

ADDRESS *123 W. 1st St*

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85416

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

108 C85416

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. *312 S. Gilman St.* ST. *19* WARD)

2-FULL NAME *Julius Numenthal*

(Residence in Baltimore: No. *312 S. Gilman St.* St. *35* yrs. *7* mos. *4* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male*

4-COLOR OR RACE *White*

5-SINGLE
MARRIED *Married*
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Oct - 12 - 1879*

7-AGE *35* yrs. *7* mos. *4* ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Foreman in a Brewery

9-BIRTHPLACE (State or country)

Baltimore, Md.

PARENTS

10-NAME OF FATHER

David Numenthal

11-BIRTHPLACE OF FATHER (State or country)

Germany

12-MAIDEN NAME OF MOTHER

Sarah Neustine

13-BIRTHPLACE OF MOTHER (State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mr. Henrietta Powell, Sister*

(Address) *1819 W. Pratt St.*

15-

ROBERT K. KRAUTH,

MAY 18 1915

Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May - 17 - 1915*

17- I HEREBY CERTIFY, That I attended deceased from *May 15, 1915*, to *May 17, 1915*, that I saw him alive on *May 17, 1915*, and that death occurred, on the date stated above, at *4:45 p.m.*

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(Duration) *About 1 1/2* yrs. mos. ds.

Contributory (SECONDARY)

Acute Peritonitis

(Duration) *1 1/2* yrs. mos. ds.

(Signed) *Christoph N. N. N. M. D.*

May 17, 1915 [Address] *333 S. Gilman St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. In the... State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

No Cathedral

DATE OF BURIAL

May 18, 1915

20-UNDERTAKER

John B. Cook

ADDRESS

1003 N. Balto St.

C85417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 C85417

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 Hull ST.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Eleanor J. Donnet

(Residence in Baltimore: No. 1229 Hull

St.; 19 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, Married

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

November 22, 1865

(Month)

(Day)

(Year)

7-AGE,

49 yrs., 5 mos., 25 ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Scotland

PARENTS.

10-NAME OF FATHER,

Andrew Johnstone

11-BIRTHPLACE OF FATHER

(State or Country),

Scotland

12-MAIDEN NAME OF MOTHER

Margaret Serringeour

13-BIRTHPLACE OF MOTHER

(State or Country),

Scotland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Shrook, M.D.

(Address).....

1570 Fort Ave.

15-

MAY 18 1915

Filed

191

ROBERT . KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 - 16 - 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov. 25 1914, to May 16 - 1915,

that I saw her alive on May 16 - 1915,

and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

(Duration) 5 yrs., mos., ds.

CONTRIBUTORY (Secondary)

Edema of Lung

(Duration) 3 yrs., mos., 2 ds.

(Signed)..... M. D.

5-18, 1915. (Address) 1570 Fort Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Woodlawn Cem

May 17, 1915.

20-UNDERTAKER

J. J. McNamee

ADDRESS

Himex North

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85418

64 C85418

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *12 S. Central Ave* ST.: *3* WARD)

2-FULL NAME *Bailey Paril*

(Residence in Baltimore: No. *12 S. Central Ave* St.: yrs. *2* mo. *1* d.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

6-DATE OF BIRTH, *1845* (Month) (Day) (Year)

7-AGE, *70* yrs. *1* mos. *1* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *No occupation* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Russia*

10-NAME OF FATHER, *Not known*

11-BIRTHPLACE OF FATHER (State or Country), *Not known*

12-MAIDEN NAME OF MOTHER, *Not known*

13-BIRTHPLACE OF MOTHER (State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *S. Malkin*

(Address) *1136 E. Pratt St.*

15- *MAY 18 1915* ROBERT . KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 18, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows: *Cerebral Hemorrhage* (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds.

(Signed) *D.W. Jones* M. D. (Coroner) *May 18, 1915* (Address) *1116 O'Donnell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Hebrew Mt. Cemetery* DATE OF BURIAL, *May 19, 1915*

20-UNDERTAKER, *J. Lounson & Co.* ADDRESS *1117 E. Pratt St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85419

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2218 North Calvert Street, 12 WARD)

2-FULL NAME Ruth Elizabeth Curry

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2218 N. Calvert St. St.; 55 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female	4-COLOR OR RACE, White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)
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6-DATE OF BIRTH, January 21 1834 (Month) (Day) (Year)

7-AGE, 81 yrs. 3 mos. 26 da.	If LESS than 1 day, ...hrs. or...min.?
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8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).	At home
--	---------

9-BIRTHPLACE, (State or Country).	Streetts, Harford Co. Md
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PARENTS.	10-NAME OF FATHER, John Streett
	11-BIRTHPLACE OF FATHER (State or Country). Harford Co., Md.
	12-MAIDEN NAME OF MOTHER Nancy Rutledge
	13-BIRTHPLACE OF MOTHER (State or Country). Harford Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexander Curry

(Address) 2218 N. Calvert St.

15- MAY 18 1915 Filed	ROBERT KRAUTER Serial Permit Clerk Registrar.
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MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2 1915, to May 17 1915, that I saw her alive on May 17 1915, and that death occurred, on the date stated above, at 3:15 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Terminal 3 days	(Duration) yrs. mos. ds.
Bronchitis - One month	One

CONTRIBUTORY (Secondary) Old Age	(Duration) yrs. mos. ds.
(Signed) Wm J. Watson M. D.	
May 18, 1915 (Address) 2128 St Paul	

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	yr.	mos.	ds.	In the	yr.	mos.	ds.
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Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Loudon Park Cemetery

5/20, 1915.

20-UNDERTAKER

ADDRESS

Henry W. Mears & Son

205 N. Calvert St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 Greenvoort Ave. 10 ST. 10 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1205 Greenvoort Ave. St. 55 yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH

Feb —, 1857
(Month) (Day) (Year)

7-AGE

58 yrs. 3 mos. — ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Ireland10-NAME OF FATHER, Stucky Kennedy11-BIRTHPLACE OF FATHER (State or Country), Ireland12-MAIDEN NAME OF MOTHER, Edith Conner13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Brooks(Address) 2926 Smith Ave.

15-

MAY 18 1915Filed 191

ROBERT KRAUTER

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 18, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 1 1915, to May 18 1915, that I saw her alive on May 16 1915, and that death occurred, on the date stated above, at 12:22 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. — mos. — ds.(Signed) James M. Benson M. D.May 18 1915 (Address) 720 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Catholic CemeteryMay 20, 1915

20-UNDER-TAKER

ADDRESS

Edmund Patrick & 433 W. 11th St.

important. See instructions on back of certificate.

C85421

HEALTH DEPARTMENT--CITY OF BALTIMORE, 45

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

WARD)

2-FULL NAME

Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and WM cert No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

white

5-SINGLE

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

Nov

3

1874

(Month)

(Day)

(Year)

7-AGE

40

yrs.

mos.

ds.

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

Letter Carrier

9-BIRTHPLACE
(State or country)

Pa.

PARENTS

10-NAME OF
FATHER

Jephannian Walker

11-BIRTHPLACE
OF FATHER
(State or country)

Pa.

12-MAIDEN NAME
OF MOTHER

Dela Souers

13-BIRTHPLACE
OF MOTHER
(State or country)

Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. Curry

J. H. Hoef

15-

MAY 18 1915

ROBERT . KRAUTER

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

15

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from
Apr 20, 1915, to May 18, 1915,that I saw him alive on May 18, 1915,
and that death occurred, on the date stated above, at 1:55 P.M.

The CAUSE OF DEATH* was as follows:

Tumor of mediastinum

(Probably malignant)

(Duration)

yrs.

4

mos.

ds.

Contributory
(SECONDARY)(Signed) Paul W. Clough
May 18, 1915 [Address] J. H. Hoef

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. 27 ds. State yrs. mos. 27 ds.

Where was disease contracted,
if not at place of death?

Former or usual residence 832 Princess St York Pa

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

York Pa

May 19, 1915

20-UNDERTAKER

ADDRESS

W. H. Hoef

North Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085422

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

109085422

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3626 Ash Ave. St. 13 WARD)

2-FULL NAME

(Residence in Baltimore: No. 3626 Ash Ave. St. yrs. mos. ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

July 18 1888

(Month) (Day) (Year)

7-AGE

56 yrs 10 mos. ds. or min.?

If LESS than 1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None (Blind)

9-BIRTHPLACE
(State or country)

Staunton Va.

10-NAME OF FATHER

Wm. Johnson

11-BIRTHPLACE OF FATHER
(State or country)

Staunton Va.

12-MAIDEN NAME OF MOTHER

Elizabeth Befford

13-BIRTHPLACE OF MOTHER
(State or country)

Staunton Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. J. Cassard

(Address) 3626 Ash Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 18 1915

(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 17, 1915, to May 18, 1915,

that I saw him alive on May 18, 1915, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

Contributory (SECONDARY) Intestinal obstruction
(Duration) yrs. mos. ds. 1
no surgical operation
(Duration) yrs. mos. ds. 1
(Signed) Vernon F. Kelly M.D.
5718 1915 [Address] 3705 Falls Rd

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mary's Hospital, Baltimore, Md. 1915

20-UNDERTAKER

ADDRESS

Chenoweth Son, Chestnut St.

MAY 18 1915

ROBERT KRAUTER
Serial Permit Clerk
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85423

CERTIFICATE OF DEATH.

151

C85423

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 413 N. Bradford

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Joseph Zaloudek*

(Residence in Baltimore: No. 413 N. Bradford

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Infant* (Write the word.)6-DATE OF BIRTH, *May 17, 1915* (Month) (Day) (Year)7-AGE, *1* yrs. *1* mos. *1* ds. If LESS than 1 day, *1* hrs. or *1* min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Infant* (b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *MD*PARENTS. 10-NAME OF FATHER, *John Zaloudek* 11-BIRTHPLACE OF FATHER (State or Country), *Austria* 12-MAIDEN NAME OF MOTHER, *Anna Hradsky* 13-BIRTHPLACE OF MOTHER (State or Country), *Austria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John J. Zaloudek* (Address) *413 N. Bradford St.*15- MAY 18 1915 Filed *ROBERT KRAUTER* Corial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 17, 1915* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest* (Inquest, au-topsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Edwin P. Russell* M. D. (Coroner.) *May 15, 1915* (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer* DATE OF BURIAL, *May 19, 1915*20-UNDERTAKER, *Frank Cracker* ADDRESS *1804 Ashland Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85424

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 C85424

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* ST. *22* WARD)

2-FULL NAME

Anna Schaper

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *402 N. Paca*St.; *55* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

unknown

(Month)

(Day)

(Year)

7-AGE.

*55*yrs. mos. ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE,

(State or Country).

Baltimore Md

10-NAME OF FATHER.

Patrick Nagle

11-BIRTHPLACE OF FATHER

(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Elizabeth

13-BIRTHPLACE OF MOTHER

(State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ellen Nagle*(Address) *1219 N. Culler St*

15-

MAY 18 1915 ROBERT KRAUTER,
Filed....., 1915 Serial. Permit. Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May**18*, *1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 24 1915, to *May 18* 1915,that I saw her alive on *May 18* 1915,and that death occurred, on the date stated above, at *7:15* P. M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

.....

..... (Duration)..... yrs. *24* mos. *24* ds.

CONTRIBUTORY

(Secondary)

..... (Duration)..... yrs. *3* mos. *24* ds.(Signed) *John S. Smith**5/18*, 1915 (Address) *Md. Gen. Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. *24* mos. *24* ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *402 N. Paca St.*

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

5/21, 1915

20-UNDERTAKER

Henry W. Mans

ADDRESS

805 N. Calvert

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85425

CERTIFICATE OF DEATH

40 C85425

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1521 Hemstead*)

ST. *9* WARD)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Joseph Bell*

(Residence in Baltimore: No. *1521 Hemstead*)

St. *58* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX <i>Female</i>	4-COLOR OR RACE <i>White</i>	5-SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Married</i> (Write the word)
6-DATE OF BIRTH <i>July 14, 1839</i> (Month) (Day) (Year)		
7-AGE <i>75</i> yrs. <i>10</i> mos. <i>3</i> ds. or min.? If LESS than 1 day, hrs.		
8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <i>Housekeeper</i>		
9-BIRTHPLACE (State or country) <i>Germany</i>		
PARENTS	10-NAME OF FATHER <i>unknown</i>	
	11-BIRTHPLACE OF FATHER (State or country) <i>Germany</i>	
	12-MAIDEN NAME OF MOTHER <i>unknown</i>	
	13-BIRTHPLACE OF MOTHER (State or country) <i>Germany</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-MAY 18 1915

ROBERT . KRAUTER

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
May 17, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY. That I attended deceased from *July 10, 1915* to *May 17, 1915*, that I saw her alive on *May 16, 1915*, and that death occurred, on the date stated above, at *5:30 a.m.*
The CAUSE OF DEATH* was as follows:

(Clinical Diagnosis)
Carcinoma of Stomach
(Duration) *Probably 1 year* ds

Contributory (SECONDARY)
George A. Hoffman M.D.
(Signed) *May 15, 1915* (Address) *1121 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

May 17, 1915

20-UNDERTAKER

ADDRESS

J.B. Stappert 2238 Fredk av

C85426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85426

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1643 Patterson Park Ave.* St.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1643 N Patterson Park Ave.* St.; *3* yrs., *4* mos., *19* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

Dec 29, *1911*
(Month) (Day) (Year)

7-AGE

3 yrs., *4* mos., *19* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....*None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Balt*

10-NAME OF FATHER,

Thos P Vaughan

11-BIRTHPLACE OF FATHER

(State or Country), *Balt*

12-MAIDEN NAME OF MOTHER

Lucie C Vaughan

13-BIRTHPLACE OF MOTHER

(State or Country), *Balt*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thos P Vaughan*(Address) *1643 N Patterson Park Ave.*

15-

MAY 19 1915

Filed

191

HARRY O. ANDREWS,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 18, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 15* 1914, to *May 18* 1915, that I saw him alive on *May 18* 1915, and that death occurred, on the date stated above, at *4 P. M.* The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration).....yrs.....mos.....*3* ds.CONTRIBUTORY
(Secondary)(Duration).....yrs.....mos.....ds.
(Signed).....*H. G. Andrews*.....M. D.
....., 191... (Address).....*634 Gough*.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.....mos.....ds. In the Stateyrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Balt Cemetery

DATE OF BURIAL,

May 17, 1915

20-UNDERTAKER

W. J. Jones

ADDRESS

1824 P. M.

important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85427

CERTIFICATE OF DEATH

REGISTERED NO. C

C85427

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1229 High al* ST. *5* WARD)

2-FULL NAME *John Brim (Brim)*

(Residence in Baltimore: No. *1229 High al* St. *19* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

colored

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

Unknown, *1*

(Month)

(Day)

(Year)

7-AGE

5-0

yrs.

mos.

ds.

IF LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Laber

9-BIRTHPLACE
(State or country)

wa

10-NAME OF FATHER

John Brim

11-BIRTHPLACE OF FATHER
(State or country)

wa

12-MAIDEN NAME OF MOTHER

Jones

13-BIRTHPLACE OF MOTHER
(State or country)

wa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edell Brim

(Address)

1229 High al

15.

MAY 19 1915

HARRY O. ANDREWS,

BURIAL PERMIT CLERK

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

5

17

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

5-17, 191*5*, to, *5-17*, 191*5*.

that I saw him alive on *5-17*, 191*5*.

and that death occurred, on the date stated above, at *8:30* m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia,
Pleuro-

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

Quel'ac Asthenia

(Duration) yrs. mos. ds.

(Signed)

S. C. Keefe

5/18, 191*5*

(Address) *116 N. 2nd St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laurel cemetery

May 19, 191*5*

20-UNDERTAKER

ADDRESS

R. B. Gross 1405 McElderry St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85428

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85428

CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1716 Keyser ST. 8 WARD) REGISTERED NO. C.
2-FULL NAME Julia Rebecca Sherrod (Sherrod)
(Residence in Baltimore: No. 1716 Keyser St. 8 yrs. 3 mos. 3 de.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE Caucas 5-SINGLE Married
6-DATE OF BIRTH Apr. 26, 1886
7-AGE 28 yrs. 5 mos. 21 ds. or 11 LESS than 1 day, hrs. min.
8-OCCUPATION (a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore City
PARENTS
10-NAME OF FATHER Riley Jackson
11-BIRTHPLACE OF FATHER (State or country) New York
12-MAIDEN NAME OF MOTHER Sarah Green
13-BIRTHPLACE OF MOTHER (State or country) Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah Green
(Address) 1716 Keyser St

MAY 19 1915

HARRY O. ANDREWS,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 17, 1915
17- I HEREBY CERTIFY, That I attended deceased from May 15, 1915, to, May 16, 1915, that I saw h-er alive on May 16, 1915, and that death occurred, on the date stated above, at 4 A m.
The CAUSE OF DEATH* was as follows:

Acute Nephritis - 6 WEEKS
Secondary to La Grippe which she
Contracted at her home in Penna.

Contributory (SECONDARY)
(Signed) Edgar P. Sandroct M. D.
May 17, 1915 [Address] 1601 N. Broadway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Laurel Cemetery DATE OF BURIAL May 22, 1915
20-UNDERTAKER Mrs. Jos. A. Lock ADDRESS 1302 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85429

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85429

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

St.: 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

MAY 19 1915

HARRY O. ADLEWIS,

Filed. 191. Burial Permit. Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Signed)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. In the State.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

C85430

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85430

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* ST. *4* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME

*Thomas Davis*Residence in Baltimore: No. *321 Park ave*St. *1* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

colored

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

Unknown, 1
(Month) (Day) (Year)

7-AGE.

35

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Barber*

9-BIRTHPLACE,

(State or Country).

Maryland

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country).

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country).

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Marie Mary Davis*(Address) *1110 Olive St*

15-

MAY 19 1915

HARRY O. ANDREWS,

Filed *May 19 1915* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 17, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 15 191*5*, to *May 17* 191*5*that I saw him alive on *May 17* 191*5*and that death occurred, on the date stated above, at *7:30* p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) *3* yrs. *3* mos. *3* ds.CONTRIBUTORY *Ch. Tubercular*
(Secondary)(Duration) *?* yrs. *?* mos. *?* ds.(Signed) *John S. Fairley* M. D.*5/17*, 191*5*. (Address) *Med Gen Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *3* mos. *3* ds. State *MD* yrs. *1* mos. *1* ds.Where was disease contracted, if not at place of death? *at home*Former or usual residence *321 Park ave*

19-PLACE OF BURIAL OR REMOVAL.

Laurel Cemetery

DATE OF BURIAL.

May 20, 1915

20-UNDERTAKER

Felix B. Pfeiffer

ADDRESS

102 E. Mulberry St

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85431

C85431

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N Arlington Ave ST.; 48 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

(Residence in Baltimore: No. 520 N Arlington Ave St.; yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH.

June 16, 1883
(Month) (Day) (Year)

7-AGE.

31 yrs., 11 mos., 2 da.If LESS than 1 day,
..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Government
Employer9-BIRTHPLACE.
(State or Country).Biological Dept. Stepanchinski
Maryland

10-NAME OF FATHER.

William F. Jones11-BIRTHPLACE OF FATHER
(State or Country).Maryland

12-MAIDEN NAME OF MOTHER

Emma Richardson13-BIRTHPLACE OF MOTHER
(State or Country).Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm F Jones(Address) 520 N Arlington Ave

MAY 19 1915

Filed..... 191.....

HARRY C. ADAMS,

Burial Permit Officer
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 17, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 1914, to May 17 1915, that I saw him alive on May 17 1915, and that death occurred, on the date stated above, at 8:30 P.m.

The CAUSE OF DEATH* was as follows:

Diabetic MelitusCONTRIBUTORY
(Secondary)(Duration) Dec 1914 1915 yrs. mos. da.(Signed) E. M. Lutzinger

M. D.

May 18, 1915. (Address) 129 E North Ave

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. da. In this State..... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Gruid Ridge CemeteryMay 19, 1915

20-UNDERTAKER

ADDRESS

Stewart Howen Co. 108 W North Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 C85432
REGISTERED NO. C.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 S. Stricker

ST. 19

WARD)

2-FULL NAME

Howard A. Stewart

(If death occurred in a hospital or institution, give its NAME instead of street and number and Room No. 18.)

(Residence in Baltimore: No. 114 S. Stricker St.

St. Lifetime

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

October

19, 1875

(Month)

(Day)

(Year)

7-AGE

39

7

3

If LESS than 1 day, hrs.,

ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Cigar Maker

9-BIRTHPLACE
(State or country)

Balto. Md.

10-NAME OF FATHER

H. H. Stewart

PARENTS

11-BIRTHPLACE OF FATHER
(State or country)

Balto. Md.

12-MAIDEN NAME OF MOTHER

Carrie Gaigley

13-BIRTHPLACE OF MOTHER
(State or country)

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carrie Whitmore

(Address)

114 S. Stricker St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

17

1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 19, 1914, to May 17, 1915,

that I saw him alive on May 17, 1915,

and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)

yrs

10

mos

ds.

Contributory
(SECONDARY)

(Duration)

yrs

mos

ds.

(Signed), Henry C. White

May 17, 1915

[Address]

1203 W. Fayette St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs

mos

ds.

In the

yrs

mos

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Cemetery May 20, 1915

20-UNDERTAKER

ADDRESS

Joseph S. Soper 1600 North Ave

MAY 19 1915

FMD 1915

HARRY O. ANDREWS,

Burial Port Registrar

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85433

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85433

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *777 George* ST. *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME

(Residence in Baltimore: No. *777 George* ST. *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE

*Colored*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Aug *15*, *1874*
(Month) (Day) (Year)

7-AGE,

20 yrs. *7* mos. *2* ds.
If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Porter*9-BIRTHPLACE,
(State or Country),*Baltimore Md*

10-NAME OF FATHER,

*Daniel Gough*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore Md*

12-MAIDEN NAME OF MOTHER

*Mary Colman*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Daniel Gough*(Address) *777 George St*

15-

MAY 19 1915

Filed..... 191.....

HARRY O. ANDERSON

Serial Form 14-010-1
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May *17*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 10th* 1915, to *May 17* 1915, that I saw him alive on *May 17* 1915, and that death occurred, on the date stated above, at *4:30 P.m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis(Duration) *unknown* yrs. mos. ds.CONTRIBUTORY
(Secondary)(Duration) *unknown* yrs. mos. ds.(Signed) *D. M. Campbell* M. D.
May 17 1915. (Address) *1349 N. E. Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

May 28, 1915.

20-UNDERTAKER

Samuel T. Henry, 578 W. Bridge

ADDRESS

important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

Balto Eye Ear and Throat Hospital

REGISTERED NO. C

76 C85434

CITY OF BALTIMORE (No.

625 W Franklin

ST. 17

WARD)

2-FULL NAME

Rose Gross

(Residence in Baltimore: No.

583 W Preston

St.:

yrs. 18

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Black

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

Sept.

16

1913

(Month)

(Day)

(Year)

7-AGE

1 6

yrs.

mos.

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Child

9-BIRTHPLACE

(State or country)

Maryland (City)

10-NAME OF FATHER

Howard Gross

11-BIRTHPLACE OF FATHER

(State or country)

Calvert Co Md.

12-MAIDEN NAME OF MOTHER

Helen Janie

13-BIRTHPLACE OF MOTHER

(State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Helen Gross

(Address)

583 W Preston St

15-

MAY 19 1915

EAST O. ANDREWS,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

18

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 17, 1915, to May 19 1915,

that I saw him alive on May 19 1915,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral spinal meningitis

(Duration)

yrs.

mos.

3 ds

Contributory

(SECONDARY)

Acute Stiles mela

(Duration)

yrs.

mos.

10 ds.

(Signed),

J. R. D. Jones

M. D.

2-18, 1915. (Address) 625 W Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

583 W Preston St

19-PLACE OF BURIAL OR REMOVAL

MT. Auburn.

DATE OF BURIAL

May 21

1915

20-UNDERTAKER

Samuel J. Hemmick

ADDRESS

578 W. Biddle

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 C85435
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *919 Burgundy* ST.; *21* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Henry B. Manser*(Residence in Baltimore: No. *919 Burgundy* St.; *27* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWER,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

April 26th, 1856
(Month) (Day) (Year)

7-AGE,

59 yrs. — mos. *21* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*Shoe Maker*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wilhelmina Manser*(Address) *919 Burgundy St.*

15-

MAY 19 1915

Filed

191

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 17th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Nov 3 1915, to May 17 1915.that I saw him alive on May 16 1915
and that death occurred, on the date stated above, at *7:30* p. m.

The CAUSE OF DEATH* was as follows:

Val. Dis. of Heart(Duration) *1* yrs. — mos. — ds.CONTRIBUTORY
(Secondary)*Rheumatism*(Duration) *1* yrs. — mos. — ds.(Signed) *Edw. J. Manser* M. D.May 18, 1915. (Address) *517 Scott St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Cemetery

DATE OF BURIAL,

May 20th, 1915.

20-UNDERTAKER

Mrs. John W. Pfeiffer, 811 W. Fayette

important. See instructions on back of certificate.

C85436

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85436

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 Eutaw Place, ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Charles Adler,(Residence in Baltimore: No. 1313 Eutaw Place, St.; 5 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,
Male,4-COLOR OR RACE,
White,5-SINGLE,
MARRIED, Widower,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Dec. 5th., 1889.
(Month) (Day) (Year)

7-AGE,

75 yrs., 5 mos., 11 da.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Wholesale
(b) General nature of industry, business, or establishment in which employed (or employer). shoe merchant,9-BIRTHPLACE,
(State or Country),Germany,

10-NAME OF FATHER,

Simon Adler,11-BIRTHPLACE OF FATHER
(State or Country),Germany,

12-MAIDEN NAME OF MOTHER

Merla, ---13-BIRTHPLACE OF MOTHER
(State or Country),Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. Adler,(Address) 1313 Eutaw Place,

15-

MAY 19 1915 HARRY O. ADLER,
Filed 1915 Sanitary Permit Office
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
1910, to May 1915,that I saw him alive on May 19 1915,
and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary pneumonia(Duration) 3 yrs., 5 mos., 11 da.CONTRIBUTORY Myocardial insufficiency
(Secondary)(Duration) 3 yrs., 5 mos., 11 da.(Signed) Harry Adler M. D.May 19, 1915. (Address) 1313 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs., 5 mos., 11 da. In the State 5 yrs., 5 mos., 11 da.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Balto. Hebrew,

DATE OF BURIAL,

May 21, 1915

20-UNDERTAKER

David Soudheim

ADDRESS

Important. See instructions on back of certificate.

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85437

HEALTH DEPARTMENT-CITY OF BALTIMORE

63

C85437

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

907 Elm Pla.

ST.

17

WARD)

2-FULL NAME

Mabel Warner

(Residence in Baltimore: No.

907 Elm Pla

St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-~~STATE~~
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Female Colored

Married

6-DATE OF BIRTH

January 28, 1894

7-AGE

21 yrs. 3 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

Md.

10-NAME OF FATHER

Wm. Hodge

11-BIRTHPLACE OF FATHER
(State or country)

Md

12-MAIDEN NAME OF MOTHER

Rosa Clark

13-BIRTHPLACE OF MOTHER
(State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rosa Clark

(Address)

907 Elm Place.

MAY 19 1915

HARRY O. ANSLER

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 18, 1915

17- I HEREBY CERTIFY, That I attended deceased from

Mar 6, 1915, to May 18, 1915.

that I saw her alive on May 17, 1915.

and that death occurred, on the date stated above, at 6.15 A.M.

The CAUSE OF DEATH* was as follows:

Acute Myelitis
(Transverse)
(Duration) yrs. mos. 7 ds.

Contributory
(SECONDARY)

(Signed) Frank E. Wagner, M.D.
May 18, 1915 (Address) 1006 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Laurel

DATE OF BURIAL

May 20, 1915

20-UNDERTAKER

Samuel T. Henry 57811 Biddle St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1012 Aisquith.

2-FULL NAME

Sarah J. Panty

(Residence in Baltimore: No. 1013 E Madison

ST. 10

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

Oct

7

1847

(Month)

(Day)

(Year)

7-AGE,

67

yrs.

7

mos.

12

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

MD

10-NAME OF FATHER,

John Kevin

11-BIRTHPLACE OF FATHER

(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Sarah M. Custer

13-BIRTHPLACE OF MOTHER

(State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Peter Des...

(Address)

613 E. Madison

15-

MAY 19 1915

HARRY O. ANDREWS,

191. Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

17

1916

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy & inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Edwin J. Russell M. D.

(Coroner.)

May 18, 1916

(Address) 423 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Vincent

DATE OF BURIAL,

May 20, 1916

20-UNDERTAKER

Wm. J. Schaffert

ADDRESS

S. J. Hunt

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085439

HEALTH DEPARTMENT--CITY OF BALTIMORE

085439

CERTIFICATE OF DEATH

1-PLACE OF DEATH *1606 N. Vincent St.*

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *1606 corner*)

ST: *15* WARD

2-FULL NAME

Larry McDowell Burgett

(If death occurred in a hospital or institution, give its NAME; instead of street and number and RH out No. 10.)

(Residence in Baltimore: No. *1606 corner*)

St.; yrs. *18* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widow

6-DATE OF BIRTH

11

(Month)

22

(Day)

1855

(Year)

7-AGE

59

yrs.

6

mos.

28

ds.

If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Seamstress

9-BIRTHPLACE

(State or country)

MD

10-NAME OF FATHER

Chas. Munroe

11-BIRTHPLACE OF FATHER

(State or country)

MD

12-MAIDEN NAME OF MOTHER

Emma Patterson

13-BIRTHPLACE OF MOTHER

(State or country)

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Betty Bates

(Address)

Reisterstown, MD

15-

MAY 19 1915

ROBERT J. KRAUTER,

Sanitary Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

5

(Month)

19

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 18

, 1915

, to,

May 19

, 1915

that I saw her alive on *May 19*, 1915

and that death occurred, on the date stated above, at *6:15 a.m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs

(Duration)

yrs.

5

mos.

ds.

Contributory (SECONDARY)

Tuberculosis

(Duration)

yrs.

mos.

ds.

(Signed)

Franklin D. C. C.

M. D.

May 19

, 1915

[Address]

755 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

in the

ds.

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reisterstown, MD

May 20, 1915

20-UNDERTAKER

ADDRESS

J. F. Eline Reisterstown

MD

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85440

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

119 C85440
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2337 Honor St ST. 23 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2337 Honor St St.; 62 yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

(Month) (Day) 18 (Year) 53

7-AGE

62 yrs. mos. ds. or min.?

If LESS than
1 day, hrs.
min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

Baltimore Md.

PARENTS

10-NAME OF FATHER

Charles Trumbo

11-BIRTHPLACE OF FATHER
(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Louis Holbrook

13-BIRTHPLACE OF MOTHER
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Wahn

(Address)

1828 Byrd St

15-

Filed

MAY 19 1915

191

ROBERT . KRAUTER

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

16, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from May 2, 1915, to, May 16, 1915,

that I saw her alive on May 16, 1915, and that death occurred, on the date stated above, at 9:45 m.

The CAUSE OF DEATH* was as follows:

Acute Brights

(Duration)

yrs.

mos.

15 ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

J. E. Wahn
May 16, 1915 [Address] 910 Right St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cedar Hill Cemetery

DATE OF BURIAL

May 20th, 1915

20-UNDERTAKER

D. M. G. Flynn

ADDRESS

1422 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85441

C85441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1031 Hanover St* ST. *23* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1031 Hanover St* St. *37* yrs., *7* mos. ds)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

Sept 15, *1877*
(Month) (Day) (Year)

7-AGE

37 yrs., *7* mos., ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Engineer
*Mariner*9-BIRTHPLACE,
(State or Country),*Balto Md*

10-NAME OF FATHER

*Martin Rudolph*11-BIRTHPLACE OF FATHER
(State or Country)*Balto Md*

12-MAIDEN NAME OF MOTHER

*Ella Woods*13-BIRTHPLACE OF MOTHER
(State or Country)*Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs. J. H. Rudolph
1031 Hanover St

15-

MAY 19 1915

ROBERT KRAUTER

Filed

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 18, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *March 20* 1915, to *May 18* 1915,that I saw him alive on *May 18* 1915,and that death occurred, on the date stated above, at *3300*

The CAUSE OF DEATH* was as follows:

Mitral insufficiency
Myocarditis(Duration) *2 1/2* yrs., *5* mos., ds.CONTRIBUTORY
(Secondary)*Cardiac debility*(Duration) *5* yrs., *5* mos., ds.

(Signed)

Gas A. Odom M. D.
May 18, 1915. (Address) *107 E. Madison St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cem

DATE OF BURIAL,

May 21, 1915

20-UNDERTAKER

W. M. G. Flynn

ADDRESS

1422 Light

Check of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85442

CERTIFICATE OF DEATH.

64 C85442

PLACE OF DEATH

CITY OF BALTIMORE: (No.)

ST. 11 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No.)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Redwood

(Address) Madison Ave

15-

MAY 19 1915

ROBERT . KRAUTER,

Filed.

191

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

5-18-1915 to 5-18-1915,

that I saw him alive on 5-18-1915,

and that death occurred, on the date stated above, at 12:00 p.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

5-18-1915 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 17 W. Mt. Royal Ave.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85443

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2908 Philadelphia Ave. ST.; 6 WARD)

REGISTERED No. C

* FULL NAME Mary A. Loy

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2908 Philadelphia Ave. St.: 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
 4-COLOR OR RACE. White
 5-SINGLE, MARRIED, WIDOW, OR DIVORCED. (Write the word.) Widow
 6-DATE OF BIRTH. October 6, 1847.
 (Month) (Day) (Year)
 7-AGE. 67 yrs., 7 mos., 13 ds.
 IF LESS than 1 day. hrs. or min.

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. housework
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
 (State or Country). Maryland

10-NAME OF FATHER. John Hantz
 11-BIRTHPLACE OF FATHER (State or Country). Pa.
 12-MAIDEN NAME OF MOTHER. Sarah Eicholtz
 13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).... Mizeppa Matthews

(Address).... 2908 Philadelphia Ave.

15- MAY 19 1915 ROBERT . KRAUTER,
 Filed. 1915 Burial Permit Clerk.
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 19, 1916.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 18, 1916, to May 19, 1916, that I saw her alive on May 17, 1916, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 12 yrs., mos., ds.
 CONTRIBUTORY Mitral Insufficiency.

(Signed) J. B. Adams, M. D.
 May 19, 1916. (Address) 2124 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
 Creagerstown Md. May 20, 1916

20-UNDERTAKER ADDRESS
 Wm. C. Black, 2126 Jefferson St.

CAUTION: OF DEATH is printed in plain text so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 C85445

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No.

St.; 9 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

May 1, 1915

(Month)

(Day)

(Year)

7-AGE.

25

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country).

Bohemia

10-NAME OF FATHER.

Charles Srejda

11-BIRTHPLACE OF FATHER
(State or Country).

Bohemia

12-MAIDEN NAME OF MOTHER

Barbara Sekyra

13-BIRTHPLACE OF MOTHER
(State or Country).

Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Anton Srejda

(Address)

2024 Ashland St.

15-

MAY 19 1915

ROBERT KRAUTER,

Filed 191. Social Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 18, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 3, 1915, to May 18, 1915,

that I saw him alive on May 17, 1915,

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. P. S. M. D.

May 19, 1915. (Address) 125 St. Mary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer

May 21, 1915

20-UNDERTAKER

ADDRESS

Frank Crocker

1946 Hollander

State of DEATH in plain text, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85446

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

C85446

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2535 E. Monument ST.; 7 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2535 E. Monument St.; — yrs., — mos., — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED, Widowed
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Feb 17, 1839
(Month) (Day) (Year)

7-AGE,

76 yrs., 2 mos., 1 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Retired
(b) General nature of industry, business, or establishment in which employed (or employer), (Labourer) X9-BIRTHPLACE,
(State or Country).Ireland

10-NAME OF FATHER,

Unknown11-BIRTHPLACE OF FATHER
(State or Country)Ireland

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. W. M. Carron(Address) 2535 E. Monument St.

15-

MAY 20 1915

EAST O. ANTHONY

Burtat Peritt, CLO. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 18, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 15 1915, May 19 1915,
that I saw him alive on May 19 1915,
and that death occurred, on the date stated above, at 7:10 m.

The CAUSE OF DEATH* was as follows:

Acute Bacterial Diphtheria(Duration) — yrs., — mos., — ds.CONTRIBUTORY
(Secondary)Arterio Sclerosis (Duration) 2 yrs., — mos., — ds.(Signed) Alvin B. Linn M. D.May 20 1915 (Address) 7187 Patterson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

New Cathedral

DATE OF BURIAL,

May 20, 1915.

20-UNDERTAKER

Lilly & Jester

ADDRESS

403 S. Wolfe

Cause of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85447

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85447

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Note Same Asquith & Ashland Ave.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *Note New York City* St. — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

July 18 1867
(Month) (Day) (Year)

7-AGE,

47 yrs. 10 mos. 1 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Teacher*
(b) General nature of industry, business, or establishment in which employed (or employer). *Religious*

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER,

Sylvester Ruth-

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Marie Werner

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sister Mary Clarissa*(Address) *Asquith & Ashland Ave.*

15-

*MAY 20 1915**HARRY O. ANDREWS*

Filed....., 191.....

MARIAL PAULIS GLO...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 19 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *May 19 1915* to *May 19 1915*that I saw him alive on *May 18 1915*, and that death occurred, on the date stated above, at *6 a* m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
terminal pneumonia
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) *F. J. Muth* M. D.
May 19 1915 (Address) *1108 North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

New York City

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Notch Cliff Balt. County**May 21, 1915*

20-UNDERTAKER

ADDRESS

*A. Fink & Son**915 P. Gay St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85448

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 C85448

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Mary's Hospital* ST.; *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2023 Woodberry av.* St.; *—* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

58

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Seamstress*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country).

Baltimore Md

10-NAME OF FATHER,

James Kelly

11-BIRTHPLACE OF FATHER

(State or Country), *Md*

12-MAIDEN NAME OF MOTHER

*Sarah Beaulieu*13-BIRTHPLACE OF MOTHER (State or Country), *W Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

The Drury
3702 Fall Rd

MAY 20 1915

HARRY O. ANDREWS,

Filed..... 101. Burial Permit Given

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 18

(Month)

(Day)

1915
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 9 191*5*, to *May 18* 191*5*.that I saw her alive on *May 18* 191*5*.and that death occurred, on the date stated above, at *7 P. m.*

The CAUSE OF DEATH* was as follows:

Hemiplegia
(Apoplexy)(Duration)..... yrs. mos. *21* ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. *3* ds.(Signed)..... *J. H. Warner* M. D.*May 18*, 191*5* (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *9* ds. In the State *5* yrs. mos. ds.Where was disease contracted, *2023 Woodberry av.*
if not at place of death?Former or usual residence *2023 Woodberry av.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Mary's Towan *May 21*, 191*5*.

20-UNDERTAKER

ADDRESS

St. Mary's Towan 3539 Fall Rd

Cause of death in plain terms so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85449

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85449

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 301 Garrison Lane ST. 20 WARD)

2-FULL NAME Frederick Kusterer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 301 Garrison Lane St.; 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

6-DATE OF BIRTH April 24, 1872 (Month) (Day) (Year)

7-AGE 43 yrs. 25 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Baker (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Germany

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Barbara

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Kusterer

(Address) 301 Garrison Lane

15-MAY 20 1915 HARRY O. ADAMS, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 19, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from March, 1915, to May 19, 1915, that I saw him alive on May 18, 1915, and that death occurred, on the date stated above, at 1:45 p.m. The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary & bronchial

(Duration) 1 yrs. mos. ds. Contributory (SECONDARY) Trauma

(Signed) Joseph G. Gieseler M. D. May 20, 1915 (Address) 1516 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lorraine Cemetery May 21, 1915

20-UNDERTAKER ADDRESS 3109

Charles W. Sill Frederick Ave.

C85450

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1012 Aisquith* ST.; *10* WARD)FULL NAME *Catherine A. Woods*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RH and No. 18.)

(Residence in Baltimore: No. *1012 Aisquith* St.; *4* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED, *Widow*
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

not known

(Month)

(Day)

(Year)

7-AGE, *about**49* yrs. *1* mos. *1* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housework*9-BIRTHPLACE,
(State or Country),*Balto. Md*

10-NAME OF FATHER,

*James M. Graw*11-BIRTHPLACE OF FATHER
(State or Country),*Ireland*

12-MAIDEN NAME OF MOTHER

*Sarah Devlin*13-BIRTHPLACE OF MOTHER
(State or Country),*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James P. Woods*(Address) *1012 Aisquith St.*

15-

Filed

MAY 20 1915

BARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 18th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 10th, 1915*, to *May 18th, 1915*, that I saw h *or* alive on *May 17th, 1915*, and that death occurred, on the date stated above, at *7 P. m.*

The CAUSE OF DEATH* was as follows:

Progressive Muscular Atrophy
Cannot say definitely
(Duration) *3* yrs. *1* mos. *1* ds.CONTRIBUTORY
(Secondary)*Ed. S. Jones*
(Signed) *Ed. S. Jones* M. D.
(Address) *1504 E. Bayview*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cemetery

DATE OF BURIAL,

May 21, 1915

ADDRESS

1301 E. Bayview

important. See instructions on back of certificate.

C85451 HEALTH DEPARTMENT—CITY OF BALTIMORE

C85451

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 943 Enoch ST. 10 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 943 Enoch St. St.; 38 yrs., 2 mos., 27 da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH

Feb. 22, 1877
(Month) (Day) (Year)

7-AGE

38 yrs., 2 mos., 27 da.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer).Latner

9-BIRTHPLACE, (State or Country),

Baltimore Md.

10-NAME OF FATHER,

John Garity.

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Ellen Dougherty

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Alfred Garity
(Address) 943 Enoch St.

15-

MAY 20 1915HARRY O. ANDREWS,Barry Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 14 1915, to May 19 1915, that I saw him alive on May 18 1915, and that death occurred, on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

La-Grippe

(Duration) yrs. mos. da.

(Signed) Russell M. D.5/19, 1915 (Address) 807 Craigth.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Patrick's Cemetery

DATE OF BURIAL,

May 22, 1915

20-UNDERTAKER

Henry Horne Sen

ADDRESS

1301 E. Enoch St.

important. See instructions on back of certificate.

C85452

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85452

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Mary Hospital*St. *10*

WARD)

REGISTERED No. C

FULL NAME

John Burke

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

(Residence in Baltimore: No. *1231 Greenmount Ave.*St. *4* yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

*MARRIED, Single**WIDOWED,**OR-DIVORCED,*

(Write the word.)

6-DATE OF BIRTH,

Unknown, 1

(Month)

(Day)

(Year)

7-AGE,

54

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Farmer*

9-BIRTHPLACE,

(State or Country),

City

10-NAME OF FATHER,

John Burke

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Margaret Taylor

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Michael Noon*(Address) *1250 E. Fort Ave*

MAY 20 1915

Filed

191

HARRY O. JELINEK,

Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

(Month)

19

(Day)

1915

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*

(Inquest, au-

topsy or inquiry.) and that said deceased came to *his* death

on the day stated above.

The CAUSE OF DEATH* was as follows:

*Suicide - jumped from 3rd floor**windows**Fracture of*(Duration) *Shock*

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

(Duration) *Shock*

yrs.

mos.

ds.

(Signed) *W. H. Chamberlain*

M. D.

(Coroner.)

May 20

1915

(Address) *18 W. Franklin St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs.

mos.

ds.

In the *pt*

yrs.

mos.

Where was disease contracted, if not at place of death?

*1231 Greenmount Ave*Former or usual residence *1231 Greenmount Ave*

19-PLACE OF BURIAL OR REMOVAL,

Cathedral

DATE OF BURIAL,

May 21, 1915

20-UNDERTAKER

Edw. J. Hamming

ADDRESS

1460 Battery

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85453

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85453

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

Aug.

24

1840

7-AGE

74

yrs.

8

mos.

23

ds.

If LESS than
1 day, —hrs.
or —min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Germany

10-NAME OF FATHER

Charles Mahna

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank A. Zimmerman

(Address)

1543 Clifton av

15-

MAY 20 1915

191

HARRY O. ANDREWS,
Sanial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

17

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 27, 1915, to May 16, 1915,

that I saw her alive on May 16, 1915,

and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Hypertensive Pneumonia

(Duration) — yrs. — mos. — ds.

Contributory
(SECONDARY)

Gangrene of foot

(Duration) — yrs. — mos. — ds.

(Signed),

Fred C. J. Smith

M. D.

May 17, 1915 (Address) 2635 Penn av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Western

DATE OF BURIAL

May 21, 1915

20-UNDERTAKER

John Field 1200 W. Lombard

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85454

CERTIFICATE OF DEATH.

28

C85454

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 E. Preston ST.; 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mamie E. Harding(Residence in Baltimore: No. 1210 E. PrestonSt.; 28 yrs., 0 mos., 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 30, 1887
(Month) (Day) (Year)

7-AGE,

28 yrs., 0 mos., 19 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE,

(State or Country),

BaltimoreMd.

10-NAME OF FATHER,

Henry C. Ahrendt

11-BIRTHPLACE OF FATHER

BaltimoreMd.

12-MAIDEN NAME OF MOTHER

Caroline Himmel

13-BIRTHPLACE OF MOTHER

BaltimoreMd.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Ahrendt(Address) 1044 Brantly ave.

MAY 20 1915

DEPT. OF HEALTH

Filed..... 191... Mar. 1st. Permit. Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1915, to May 18, 1915, that I saw her alive on May 18, 1915, and that death occurred, on the date stated above, at 22 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) 1 yrs., 7 mos., 7 ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs., 7 mos., 7 ds.(Signed) J. Lee Maguire, M. D.May 19, 1915 (Address) 1206 E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Widow Park

DATE OF BURIAL,

May 20, 1915

20-UNDERTAKER

Edwin Boon

ADDRESS

507 E. North

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

C85455

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85455

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No.....

ST.:..... WARD)

2-FULL NAME

(Residence in Baltimore: No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

MAY 20 1915

Filed

191

HARRY O. ANDREWS,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

3/22, 1915, to, 5/18, 1915,

that I saw her alive on May 18, 1915, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Chronic Nephritis
Acute Pyelitis

(Duration) 3 mos.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

M.B. Levine N. D.
5/18, 1915. [Address] Hebrew Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs. 1 mos. 26 ds. State 31 yrs. 9 mos. 2 ds.

Where was disease contracted, If not at place of death? 510 N Patterson PK Ave

Former or usual residence 510 N Patterson PK Ave

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Lottehead

May 18, 1915

20-UNDERTAKER

ADDRESS

John Cook

507 E. N. Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85456 HEALTH DEPARTMENT—CITY OF BALTIMORE

C85456

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1415 Eastern Ave.

ST.: 3

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

August Hellmke

(Residence in Baltimore: No.

Not known

St.: yrs. not known mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Not known
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Not known, 1

(Month)

(Day)

(Year)

7-AGE,

55

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Baker

9-BIRTHPLACE,
(State or Country),

Supposed to be Germany

Not known

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER
(State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER
(State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

MAY 20 1915.

Filed.....

191.....

HARRY O. ANDREWS,
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

5th

1915.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest,
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)..... yrs. mos. da.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. da.

(Signed).....

David W. Jones, M. D.
(Coroner.)

May 10, 1915. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. da. In the State..... yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

May 19, 1915.

20-UNDERTAKER

ADDRESS

A. V. W. S. WOODALL.

FOR ANATOMICAL PURPOSES.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Eastern ave 3

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1006 Eastern ave

St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH

May 17, 1915
(Month) (Day) (Year)

7-AGE

yrs. mos. 3 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE

(State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER

Vincent

11-BIRTHPLACE OF FATHER

(State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Albina Schiavone

13-BIRTHPLACE OF MOTHER

(State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Infant

(Address) 1006 Eastern ave

15-

MAY 20 1915

HARRY C. ANDREWS,

Filed.....

191

Bureau of Health

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 20, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 17, 1915, to May 20, 1915,

that I saw her alive on May 20, 1915,

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. L. Valentin M. D.
May 20, 1915 (Address) 16 So. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St Vincent

DATE OF BURIAL,

May 20, 1915

20-UNDERTAKER

Wendell Duffel

ADDRESS

375 N. ...

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85458

CERTIFICATE OF DEATH.

REGISTERED NO. C

120 C85458

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)

6-DATE OF BIRTH,

unknown 1853
(Month) (Day) (Year)

7-AGE,

62

yrs. mos. ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

France

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

Corsica

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Corsica

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Anna Burns*(Address) *840 E. Chatham St.*

15-

MAY 20 1915

ROBERT KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 18, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 19* 1915, to *May 18* 1915,

that I saw him alive on *May 18* 1915,and that death occurred, on the date stated above, at *23 A.* m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis(Duration) *9* yrs. *9* mos. *2* ds.

CONTRIBUTORY (Secondary)

(Duration) *2* yrs. *2* mos. *2* ds.(Signed) *W. J. Warner* M. D.*May 18*, 1915. (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *29* yrs. *29* mos. *29* ds. In the State *29* yrs. *29* mos. *29* ds.

Where was disease contracted, if not at place of death? *840 E. Chatham St.*Former or usual residence *840 E. Chatham St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer May 21, 1915

20-UNDERTAKER

ADDRESS

Joe J. Kern 1915 Fayette

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85459

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170
C85459

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *205 N. Pine* ST. *4* WARD)

FULL NAME *Marie A. Eilermann*

(Residence in Baltimore: No. *205 N. Pine St.* St. yrs. mos. *4* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married* (Write the word)

6-DATE OF BIRTH *Aug. 28, 1836* (Month) (Day) (Year)

7-AGE *78* yrs. *8* mos. *9* ds. If LESS than 1 day, hrs. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country)

Germany

10-NAME OF FATHER

Johannes

11-BIRTHPLACE OF FATHER (State or country)

Germany

12-MAIDEN NAME OF MOTHER

Mary Seltrmann

13-BIRTHPLACE OF MOTHER (State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. E. Albers*

(Address) *205 N. Pine St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 19, 1915* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *May 16, 1915*, to, *May 18, 1915*

that I saw her alive on *May 18, 1915*

and that death occurred, on the date stated above, at *1:25 A.m.*

The CAUSE OF DEATH* was as follows:

*Chronic Interstitial Nephritis
Arteriosclerosis*

(Duration) *5* yrs. *—* mos. *—* ds.
Contributory (SECONDARY) *Neurasthenia (Sexual) Semivital
Cardiac Asthenia*

(Signed) *G. A. Thiede* M. D.
7-9, 1915 (Address) *1530 W. Franklin*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park *May 21, 1915*

UNDERTAKER

Geo. J. Kern 1914 E. Fayette

15 MAY 20 1915

ROBERT J. KRAUTER
Burial Permit Clerk
REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085460

HEALTH DEPARTMENT--CITY OF BALTIMORE

085460

CERTIFICATE OF DEATH

108

1-PLACE OF DEATH *Hebrew Hospital*
CITY OF BALTIMORE: (No. *Portland Ave & Monument* ST. *6* WARD)
2-FULL NAME *Mr John Sparr (Sparr)*
(Residence in Baltimore: No. *111 N. Wolfe* St.; *65* yrs. *65* mos. *65* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and R.R. No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX <i>male</i>	4-COLOR OR RACE <i>white</i>	5-SINGLE MARRIED <i>married</i> WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH <i>April 24 1847</i> (Month) (Day) (Year)		
7-AGE <i>68</i> yrs. <i>1</i> mos. <i>65</i> ds. or min.? If LESS than 1 day, hrs.		
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <i>Carpenter</i>		
9-BIRTHPLACE (State or country) <i>Germany</i>		
PARENTS	10-NAME OF FATHER <i>Not known</i>	
	11-BIRTHPLACE OF FATHER (State or country) <i>Germany</i>	
	12-MAIDEN NAME OF MOTHER <i>Not known</i>	
	13-BIRTHPLACE OF MOTHER (State or country) <i>Germany</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Catherine Sparr*
(Address) *111 N. Wolfe St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
May 20 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *5-15-1915* to *5-20-1915*, that I saw him alive on *5-20-1915*, and that death occurred, on the date stated above, at *6:52 A.M.*
The CAUSE OF DEATH* was as follows:
Apoplexy with pneumonia
(Duration) yrs. mos. ds. *20* ds.
Contributory (SECONDARY) *Pneumonia*
(Duration) yrs. mos. ds. *1* ds.
(Signed) *M. B. Levine* M. D.
5-20-1915 [Address] *Hebrew Hosp*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death yrs. mos. *5* ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death? *111 N. Wolfe St.*
Former or usual residence

MAY 20 1915
ROBERT KRAUTER, REGISTRAR
Burial Permit No. *101*
19-PLACE OF BURIAL OR REMOVAL *New Cathedral* DATE OF BURIAL *May 24 1915*
20-UNDERTAKER *Joe J. Ben 1914 E. Fayette* ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85461

C85461

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *22* ST.; *22* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *819 Bevan* St.; *819* yrs., *8* mos., *7* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

Black

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Sept *12*, *1868*
(Month) (Day) (Year)

7-AGE.

46 yrs., *8* mos., *7* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE,

(State or Country), *MD*

10-NAME OF FATHER,

Wm. H. Hackett

11-BIRTHPLACE OF FATHER (State or Country),

MD

12-MAIDEN NAME OF MOTHER

Mary Hackett

13-BIRTHPLACE OF MOTHER (State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert Krauter*(Address) *1400 Mosher St.*

15-

Filed

MAY 20 1915

ROBERT KRAUTER,

Serial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May *19*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 18*, *1915*, to *May 19*, *1915*, that I saw him alive on *May 19*, *1915*, and that death occurred, on the date stated above, at *11:40 a.m.*
The CAUSE OF DEATH* was as follows:*Uremia*
Cerebral Hemorrhage
(Duration) *2* yrs., *2* mos., *2* ds.

CONTRIBUTORY (Secondary)

Chronic Intestinal Neph.
(Duration) *3* yrs., *3* mos., *2* ds.(Signed) *John S. Fink**5/19/15*, *1915* (Address) *MD General Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs., *2* mos., *2* ds. In the State *MD*.

Where was disease contracted, if not at place of death?

Former or usual residence *819 Bevan St.*

19-PLACE OF BURIAL OR REMOVAL,

Laurel

DATE OF BURIAL,

May 20, 1915

20-UNDERTAKER

Wm. H. Chase & Son

ADDRESS

1400 Mosher St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85462

CERTIFICATE OF DEATH.

172 C85462
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1930 W. Pratt St.

ST.: 20 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1930 W. Pratt St.

St.: 6 yrs., 6 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH

7-AGE

10 LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

May 18, 1915. (Address) 1735 Hollen

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

MAY 20 1915

ROBERT K. KRAUTER

Burial Permit Clerk

Registrar.

New Cathedral

May 21, 1915.

Res. L. Schrab & Bro

2101 Redk. Ave.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85463

HEALTH DEPARTMENT--CITY OF BALTIMORE

50 C85463

CERTIFICATE OF DEATH

PLACE OF DEATH *Hebrew Hospital*
CITY OF BALTIMORE: (No. *Rutland Ave & Monument* ST. *17* WARD)
FULL NAME *Frank Ross*
(Residence in Baltimore: No. *# 603 Pennsylvania Ave* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* COLOR OR RACE *White* SINGLE MARRIED *Married* WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH *May 19 1883*
(Month) (Day) (Year)

AGE *32* yrs. mos. ds. or min. If LESS than 1 day, hrs. min.?

OCCUPATION (a) Trade, profession or particular kind of work *Storekeeper* (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country) *Austria Hungary*

PARENTS 10-NAME OF FATHER *John Ross*

11-BIRTHPLACE OF FATHER (State or country) *Hungary*

12-MAIDEN NAME OF MOTHER *May Perina*

13-BIRTHPLACE OF MOTHER (State or country) *Hungary*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Katie Ross*

(Address) *603 Pennsylvania Ave*

MAY 20 1915 ROBERT KRAUTER, Registrar
Filed 191 Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *May 19 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *5/17*, 191*5*, to, *5/19*, 191*5*, that I saw him alive on *5/19*, 191*5*, and that death occurred, on the date stated above, at *11:54 a.m.*
The CAUSE OF DEATH* was as follows:
Senility

Contributory (SECONDARY) *Coronary* (Duration) yrs. mos. ds.

(Signed) *M. B. Levine* M. D. (Duration) yrs. mos. ds. *3*
5/19, 191*5* [Address] *Hebrew Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *3* In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? *# 603 Penn Ave Balt.*

Former or usual residence *4110 Falls Road*

19-PLACE OF BURIAL OR REMOVAL *St Peters Cemetery* DATE OF BURIAL *5/21*, 191*5*

20-UNDERTAKER *Robt Brooks Son & Co* ADDRESS *S. E. Cor Calhoun & Hollins*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85464

CERTIFICATE OF DEATH.

113 C85464
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *404 N. Collington Ave* ST.: *6* WARD)2-FULL NAME *Conrad F. Lebrun*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *404 N. Collington Ave* St.: *unknown* yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)6-DATE OF BIRTH, *May 27*, 18*49*
(Month) (Day) (Year)7-AGE, *65* yrs. *11* mos. *21* ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Engineer*
(b) General nature of industry, business, or establishment in which employed (or employer), *Stationary*9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Leva Lebrun*(Address) *404 N. Collington Ave*15-*MAY 20 1915* *ROBERT KRAUTER,*
Filed..... 191*5* *Marial Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 18*, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY. That I attended deceased from *MAY 24* 191*5* to *MAY 2* 191*5*,
that I saw him alive on *MAY 18* 191*5*,
and that death occurred, on the date stated above, at *11:20* a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage of Liver
(Duration) *2* yrs.mos.ds.CONTRIBUTORY (Secondary) *Calculation*
(Duration)yrs.mos.ds.(Signed) *Fred Conville* M. D.
May 16, 191*5*. (Address) *2229 E. Maco St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park Cemetery* DATE OF BURIAL, *May 21*, 191*5*20-UNDERTAKER, *Christian Miller* ADDRESS *2334 E. Pratt St*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85465

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28

C85465

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *1934 White St.* ST. *20* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Jessie E. Lonesome*
(Residence in Baltimore: No. *1934 White St.* St. *22* yrs. *11* mos. *26* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *Col* 5-SINGLE *Married*
6-DATE OF BIRTH *May 22nd 1892* (Month) (Day) (Year)
7-AGE *22* yrs. *11* mos. *26* ds. or min. If LESS than 1 day, hrs., min.
8-OCCUPATION (a) Trade, profession or particular kind of work *Porter* (b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE (State or country) *MD*
10-NAME OF FATHER *Washington Lonesome*
11-BIRTHPLACE OF FATHER (State or country) *VA*
12-MAIDEN NAME OF MOTHER *Netie Washington*
13-BIRTHPLACE OF MOTHER (State or country) *VA*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

ROBERT . KRAUTER,

MAY 20 1915

Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 18th 1915* (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *March 29th 1915* to *May 18th 1915*, that I saw him alive on *May 17th 1915*, and that death occurred, on the date stated above, at *9:00* m. The CAUSE OF DEATH* was as follows:
Infection of lungs

Contributor (SECONDARY)

Chronic Nephritis (Duration) *3* yrs. *6* mos. *6* ds.
Robert L. Lonesome (Address) *52071 Fennell*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt. Zion Cemetery

DATE OF BURIAL

May 21st 1915

20-UNDERTAKER

George N. Holland

ADDRESS

572 Robert Street

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85466

CERTIFICATE OF DEATH.

120

C85466

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

404 Bowers Court

ST. 12 WARD

REGISTERED NO. C

FULL NAME

Robert J. Green

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No.

404 Bowers Court

St. 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE

C.C.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

December, 1860

(Month)

(Day)

(Year)

7-AGE,

55

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

Day Laborer

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Robert J. Green

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jane Peters

(Address)

404 Bowers Court

15

MAY 20 1915

Filed

191

ROBERT J. KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

3-20, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Apr 4 1915, to May 19 1915,

that I saw him alive on May 19 1915,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 15 yrs. ds.

(Signed) R. Garland Abbott M. D.

May 20, 1915. (Address) 424 East 23 St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

May 22, 1915

20-UNDERTAKER

George N. Holland

ADDRESS

Robert St.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85467

CERTIFICATE OF DEATH

109

C85467

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C.

CITY OF BALTIMORE: (No.

Rutland Ave & Monument St.

14

WARD)

2-FULL NAME

Mr. Robt S. Stern

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

2025 Madison Ave

St.

32

Yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Oct

(Month)

(Day)

1853

(Year)

7-AGE

61

Yrs.

7

Mos.

ds.

If LESS than

1 day, hrs.,

or min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Butcher

9-BIRTHPLACE

(State or country)

Germany

10-NAME OF FATHER

Abraham Stern

11-BIRTHPLACE

OF FATHER

(State or country)

Germany

12-MAIDEN NAME

OF MOTHER

Hersa Bachrach

13-BIRTHPLACE

OF MOTHER

(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Myr. D. Stern

(Address)

2025 Madison Ave

15-

MAY 20 1915

Filed

191

ROBERT J. KRAUTER

Chief Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

(Month)

19

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

5/14

1915

to,

5/19

1915

that I saw him alive on

5/19

1915

and that death occurred, on the date stated above, at

9:10

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
(Caused by Coliculus)

(Duration)

Yrs.

Mos.

5 ds.

Contributory
(SECONDARY)

Pneumonia Bronchitis

(Duration)

Yrs.

Mos.

2 ds.

(Signed),

M. B. Levin

M. D.

5/19

1915

[Address]

Hebrew Hosp

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

Yrs.

Mos.

In the

State

Yrs.

Mos.

ds.

Where was disease contracted, if not at place of death?

2025 Madison Ave

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chet Sholomew

May 21

1915

20-UNDERTAKER

ADDRESS

David Kondheim

1101 Mt Royal Ave

Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

685468

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

134 685468

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *2* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Jennie Bass
321 S. Bond

(Residence in Baltimore: No. *321 S. Bond* St. *10* yrs. *10* mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

Married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

May 20, *1889*
(Month) (Day) (Year)

7-AGE

31 yrs. *10* mos. *10* ds. If LESS than 1 day, *1* hrs. *10* min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE
(State or country)

Russia

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER
(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Lewis
1419 E. Balto St

15-

MAY 20 1915

ROBERT J. KRAUTER,

Morial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 20, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 15, *1915*, to, *May 20*, *1915*,

that I saw her alive on *May 20*, *1915*,

and that death occurred, on the date stated above, at *7:30 p.m.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Accidental 7 month miscarriage

Contributory
(SECONDARY)

(Duration) yrs. *7* mos. *10* ds.
Acute Myocardial Dilatation

(Signed)

5/20, *1915*

(Duration) yrs. *1* mos. *1* ds.
M. B. Levine M. D.

[Address] *Hebrew Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. *6* mos. *15* ds. In the State *15* yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death? *321 S. Bond St.*

Former or usual residence *321 S. Bond St.*

19-PLACE OF BURIAL OR REMOVAL

Hebrew Rosedale

DATE OF BURIAL

5/21, *1915*

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Balto

C85469

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85469

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *578 N. Preston* ST. *17* WARD)

2-FULL NAME

Philip G. Blackston(Residence in Baltimore: No. *578 N. Preston St.* St. *17* yrs. *47* mos. *—* ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

Colored

5-SINGLE

Married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

Unknown 1868
(Month) (Day) (Year)

7-AGE

47 yrs. *—* mos. *—* ds. or min.?If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Porter*
*Greeny street*9-BIRTHPLACE
(State or country)*Baltimore Md*

10-NAME OF FATHER

*Thos Philip Blackston*11-BIRTHPLACE OF FATHER
(State or country)*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or country)*Howard Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Blackston

(Address)

578 N. Preston St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 18, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 16th*, 1915, to *May 18th*, 1915, that I saw him alive on *May 18th*, 1915, and that death occurred, on the date stated above, at *10 P. m.*
The CAUSE OF DEATH* was as follows:Contributory
(SECONDARY)*Endocarditis*

(Signed)

Edward G. MacIntyre M. D.
May 20th, 1915 [Address] *1339 N. North Ave*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mt Auburn Cemetery**May 21st*, 1915

20-UNDERTAKER

ADDRESS

Felix B. Pye, *102 E. Mulberry St.*

MAY 21 1915

Filed

191

HARRY O. ABRENS,

Bureau Permit Clerk

REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.

C85470

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85470

CERTIFICATE OF DEATH.

28
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 Eastern Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. 2018 Eastern Ave St.: 59 yrs., 10 mos., 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE, <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <u>Widow</u> (Write the word.)
6-DATE OF BIRTH, <u>June 22nd</u> , <u>1855</u> (Month) (Day) (Year)		
7-AGE, <u>59</u> yrs., <u>10</u> mos., <u>26</u> ds.		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work... (b) General nature of industry, business, or establishment in which employed (or employer)...		
<u>Retired</u> <u>Housework</u>		
9-BIRTHPLACE, (State or Country), <u>Balto. Md.</u>		

PARENTS.

10-NAME OF FATHER, <u>Patrick Cosgrove</u>
11-BIRTHPLACE OF FATHER (State or Country), <u>Ireland</u>
12-MAIDEN NAME OF MOTHER <u>Julia Hanigan</u>
13-BIRTHPLACE OF MOTHER (State or Country), <u>Ireland</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Cleary(Address) 2018 Eastern Ave.

15-

MAY 21 1915

Filed 1915 May 21 1915 10:10 AM 1915
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,
May, 18, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
May 29 1915, to May 18 1915,
that I saw her alive on May 18 1915,
and that death occurred, on the date stated above, at 4:45 m.
The CAUSE OF DEATH* was as follows:Tuberculosis - Pulmonary
Emphysema
(Duration).....yrs. 1 mos. 20 ds.CONTRIBUTORY
(Secondary).....(Signed) Dr. J. M. D.
May 18, 1915 (Address) 1018 E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Our Cathedral May 21, 1915.

20-UNDERTAKER ADDRESS

Lilly & Green 4033 Wolfe

Statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85471

CERTIFICATE OF DEATH

64
REGISTERED NO. C

C85471

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2220 Gough St)

ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2 FULL NAME

Charles Fritsch

Residence in Baltimore: No. 2220 Gough

St. 43 yrs. 4 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Jan. 12th, 1872
(Month) (Day) (Year)

7 AGE

43 yrs. 4 mos. 6 ds. or min. 7

If LESS than
1 day, hrs.
or min. 7

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Butcher

9 BIRTHPLACE
(State or country)

Balto. Md.

10 NAME OF FATHER

Elias H. Fritsch

PARENTS

11 BIRTHPLACE OF FATHER
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Elizabeth Pennig

13 BIRTHPLACE OF MOTHER
(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ella C. Fritsch

(Address)

2220 Gough St.

15

MAY 21 1915

MARY O. ADAMS

Serial Permit No. 10

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 18, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from

December 31, 1914, to May 18, 1915.

that I saw him alive on May 18, 1915,
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Lymphoma

(Duration) yrs. mos. 1 ds.

Contributory
(SECONDARY)

Paralysis

(Duration) yrs. mos. 1 ds.

(Signed)

E. C. Fritsch

M. D.

May 19, 1915 (Address) 2000 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Schwartz's Cem.

DATE OF BURIAL

May 21, 1915

UNDERTAKER

Lilly Green

ADDRESS

403 S. Wolfe St.

16. b. — Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85472

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85472

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 21 1915

MARY O. ANDREWS,

191. Serial. Permit. Officer

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

191. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

C85473

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85473

CERTIFICATE OF DEATH.

PLACE OF DEATH

City of Baltimore (No. *St Josephs Hospital* ST: *10* WARD)Full Name *Julius Nathanson*Residence in Baltimore: No. *1127 1/2 1/2 St*

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *2* yrs., *0* mos. *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

*May**20*, *1913*
(Month) (Day) (Year)

7-AGE,

*2**0**0**0**0**0**0**0**0**0**0**0*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Child*9-BIRTHPLACE,
(State or Country),*MD (City)*

10-NAME OF FATHER,

*Daniel Nathanson*11-BIRTHPLACE OF FATHER
(State or Country),*Russia*

12-MAIDEN NAME OF MOTHER

*Sarah Michaelson*13-BIRTHPLACE OF MOTHER
(State or Country),*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

D. Nathanson

(Address)

1127 1/2 1/2 St

15-

MAY 21 1915

101. *Serial Permit*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May**20**1915*
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest*
(Inquest, au-topsy or inquiry.) and that said deceased came to *this* death
on the day stated above.

The CAUSE OF DEATH* was as follows:

*Unavoidable Accident by being
run over by a wagon May 20, 1915*

(Duration).... yrs.... mos.... ds.

CONTRIBUTORY
(Secondary)

(Duration).... yrs.... mos.... ds.

(Signed) *Elijah L. Russell* M. D.*May 20, 1915* (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?....

Former or usual residence *1127 1/2 1/2 St*

19-PLACE OF BURIAL OR REMOVAL.

PLACE OF BURIAL

*Woodlawn Cem**MAY 21 1915*

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85474

CERTIFICATE OF DEATH.

C85474

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1824 Penneywood Ave* St. *—* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

single

6-DATE OF BIRTH,

Aug. 4, 1858
(Month) (Day) (Year)

7-AGE,

56 yrs. 9 mos. 17 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Secord Mercy Hosp*(Address) *Calvert Street*

15-

MAY 21 1915

Filed *191* *Marial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 7, 1915, to May 21, 1915,*that I saw him alive on *May 21, 1915,*and that death occurred, on the date stated above, at *3:00 p.m.*

The CAUSE OF DEATH* was as follows:

*Mitral Regurgitation**about* (Duration) *4* yrs. *4* mos. *—* ds.

CONTRIBUTORY (Secondary)

Coronary atherosclerosis (Duration) *3* yrs. *—* mos. *—* ds.(Signed) *Edward P. Smith* M. D.*May 21, 1915* (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *14* yrs. *—* mos. *—* ds. In the *14* yrs. *—* mos. *—* ds.Where was disease contracted? *1824 Penneywood Ave*
if not at place of deathFormer or usual residence *1824 Penneywood Ave*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Unionbridge Rd *May 21, 1915*

20-UNDERTAKER

ADDRESS

Wm. W. Watson *2301 Green*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85475

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85475

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Little Sisters of the Poor* 10 WARD)

2-FULL NAME

Owen Cullan(Residence in Baltimore: No. *Little Sisters of the Poor*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

Unknown, 1838

(Month)

(Day)

(Year)

7-AGE.

77

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Tailor

9-BIRTHPLACE.

(State or Country).

Ireland

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER (State or Country).

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Sister Benedict

(Address).

Little Sisters of the Poor

15-

MAY 21 1915

DEPT. OF HEALTH

101. Burial Permit. 0101

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 20th, 1915.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquiry* (Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Elyse L. Russell M. D.

(Coroner.)

May 20, 1915 (Address) *423 N. Broadway*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Cross May 21, 1915

20-UNDERTAKER

ADDRESS

H.C. Wiedfeld 914 Green Mt. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85476

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79

C85476

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.

Hebrew Hospital

ST.

3

WARD)

2-FULL NAME

Katie Caplan

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

302 S. Spring

St.:

20

Yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

Unknown 1869

(Month)

(Day)

(Year)

7-AGE

46

Yrs.

mos.

ds.

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Russia

10-NAME OF FATHER

Louis Ditch

11-BIRTHPLACE OF FATHER
(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hyman Shemer

(Address)

111 E Pratt St

MAY 21 1915

Filed

191

HARRY O. ANDREWS,

Sanial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 21 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 15, 1915, to May 21, 1915,

that I saw her alive on May 21, 1915,

and that death occurred, on the date stated above, at 6:29 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Chronic Myocarditis

(Duration)

3

Yrs.

mos.

ds.

Contributory
(SECONDARY)

Embolic of Left middle Cerebral artery

(Duration)

Yrs.

mos.

7

ds.

(Signed)

M. B. Levine

M. D.

5/21 1915

[Address]

Hebrew Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

Yrs.

mos.

7

In the

20

Yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

302 S. Spring St.

Former or usual residence

302 S. Spring St.

19-PLACE OF BURIAL OR REMOVAL

Hebrew Mt Carmel

DATE OF BURIAL

May 21 1915

20-UNDERTAKER

S. Levine & Co. Balto St

ADDRESS

1107 E

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85477

CERTIFICATE OF DEATH.

152

C85477

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. *Female*

4-COLOR OR RACE, *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *May 16th, 1915*
(Month) (Day) (Year)

7-AGE, If LESS than 1 day.
yrs. mos. ds. hrs. or 15 min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE.
(State or Country).*England (bites)*
Unknown

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15- MAY 21 1915

Filed..... 191.....

LARRY O. ADAMS,

Baltimore, Md.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 16th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

..... 191, to 191,
that I saw h..... alive on 191

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Strangulation of cord
in delivery
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)(Signed) *E. H. Hayward* M. D.
John A. Maguire
May 17, 1915 (Address) *838 E. Preston St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death *St. Vincent's Infant Asylum*Former or usual residence *St. Vincent's Infant Asylum*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Cathedral *May 21, 1915*

UNDERTAKER

ADDRESS

Tracy & Sons 606 E. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85478

C85478

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3725 Marley ST. 20 WARD)

REGISTERED NO. C

2-FULL NAME Charles O. Huntington

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3725 Marley St.; — yrs., — mos., — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Married

6-DATE OF BIRTH

Unknown, 1852
(Month) (Day) (Year)

7-AGE

63 yrs. — mos. — da. — hrs. or — min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Upholsterer9-BIRTHPLACE,
(State or Country)Germany

10-NAME OF FATHER

O. Huntington11-BIRTHPLACE OF FATHER
(State or Country)Germany

12-MAIDEN NAME OF MOTHER

C. Bender13-BIRTHPLACE OF MOTHER
(State or Country)Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Huntington(Address) 3725 Marley

15-

MAY 21 1915

HARRY C. ANDREWS,

Baptist Par. Mt. Oliv.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 20, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 1, 1914, to May 20, 1915,that I saw him alive on May 20, 1915,and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Chronic
hepatitis & nephritis(Duration) 1 yrs. — mos. — da.CONTRIBUTORY
(Secondary)Exhaustion(Duration) — yrs. — mos. — da.(Signed) J. T. O'Mara M. D.May 21, 1915 (Address) 1042 Edman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — da. In the State — yrs. — mos. — da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cathedral

DATE OF BURIAL

May 21, 1915

20-UNDERTAKER

John F. Jones, Son of J. F. Jones

ADDRESS

1042 Edman St.

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85479

HEALTH DEPARTMENT—CITY OF BALTIMORE

18

C85479

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *835 Columbia Ave* ST.; WARD)2-FULL NAME *Mary E Weber (Weber)*(Residence in Baltimore: No. *835 Columbia Ave* St.; yrs. *1* mos. *73* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

white

5-STATUS

Widow
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH

March

(Month)

26

(Day)

1851

(Year)

7-AGE

64

yrs.

1

mos.

73

ds.

If LESS than 1 day.

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),*Baltimore Md*

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country), *Germany*

12-MAIDEN NAME OF MOTHER

Catherine Traeger

13-BIRTHPLACE OF MOTHER

(State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph E. Weber*(Address) *835 Columbia Ave*

15-

MAY 21 1915

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

(Month)

18

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar 12 1915, to *May 18* 1915that I saw him alive on *May 18* 1915,and that death occurred, on the date stated above, at *12:30* a.m.

The CAUSE OF DEATH* was as follows:

Erysipelas of leg(Duration) yrs. *2* mos. *2* ds.CONTRIBUTORY
(Secondary)*Suppression of circulation*(Duration) yrs. *2* mos. *2* ds.(Signed) *J. M. L. Campbell* M. D.*May 18, 1915* (Address) *826 N. Carroll St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *73* ds. In the State yrs. *1* mos. *73* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Western Cemetery

DATE OF BURIAL

May 21, 1915

20-UNDERTAKER

Joseph E. Cook

ADDRESS

1053 N. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 24 1915

Q85480

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1152 Calverton St. ST. 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 113-E Clement. ✓)

St.; — yrs., — mon., — day)

MEDICAL CERTIFICATE OF DEATH.

3-SEX.

4-COLOR OR RACE.

8-SINGLE,
MARRIED, *Widowed*
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Feb 22^d, 1833.
(Month) (Day) (Year)

7-AGE.

83- yrs. 2 mos. 18 da.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country).

10-NAME OF
FATHER.

11-BIRTHPLACE
OF FATHER
(State or Country).

12-MAIDEN NAME
OF MOTHER

**13-BIRTHPLACE
OF MOTHER
(State or Country).**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

15- MAY 21 1915

RASHY & ADULTS.

Filed..... 191...
Registrar.

16-DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
Aug 12th 1915, to Aug 13th 1915.
that I saw him alive on Aug 13th 1915,
and that death occurred, on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.
----------------------	------	------	-----	-----------------	------	------	-----

Where was disease contracted,
if not at place of death?

Former or
usual residence

10-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDEKTAKER

ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85481

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85481

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *735 W. Lexington*)

ST. *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME

Frances Palaskis

Residence in Baltimore: No. *735 W. Lexington*

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single

6-DATE OF BIRTH

May

12th, 1915

7-AGE

yrs. *9* ds. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Baltimore City.

10-NAME OF FATHER

John Palaskis

11-BIRTHPLACE OF FATHER

(State or country)

Russia

12-MAIDEN NAME OF MOTHER

(State or country)

Anna Mikalaitis

13-BIRTHPLACE OF MOTHER

(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Palaskis

(Address)

735 W. Lexington St.

15-

MAY 21 1915

HARRY O. ARLEWIS,

Barial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

21st, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 20th, 1915* to *May 21st, 1915*, that I saw her alive on *May 20th, 1915*, and that death occurred, on the date stated above, at *4 P. M.* The CAUSE OF DEATH* was as follows:

Institution

(Duration)

from birth

Contributory (SECONDARY)

Exhaustion

(Duration)

yrs. mos. ds.

(Signed)

G. S. Elwood

M. D.

May 21st, 1915 (Address) *1000 S. 5th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

Where was disease contracted?

If not at place of death?

Former or

usual residence

In the

State

yrs.

mos.

ds.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeemer

May 21st, 1915

20-UNDERTAKER

ADDRESS

John Gebhard

505 S. 10th St.

C85482

HEALTH DEPARTMENT—CITY OF BALTIMORE

159 C85482

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1414 Jackson

ST.

WARD) 24

FULL NAME

(Residence in Baltimore: No. 1414 Jackson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

26 yrs. / mon. 5 da)

PERSONAL AND STATISTICAL PARTICULARS.

SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILE

MAY 21 1915

HARRY O. ANDREWS

Burial Permit Officer

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 20, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide by Pistol shot in head
(Duration) yrs. mon. ds.

CONTRIBUTORY (Secondary)

(Signed)

(Duration) yrs. mon. ds.

(Address) May 20, 1915.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mon. ds. State yrs. mon. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Hill Cemetery

May 22, 1915

ADDRESS

20-UNDERTAKER

Mrs J. E. Wansel

1428 Charles St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085483

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 085483

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 832 Tressier

ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME John Brooks

(Residence in Baltimore: No. 832 Tressier

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Unknown, 1844

7-AGE

71

If LESS than

1 day, hrs.

yrs. mos. ds. or min. 7

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Old Soldier
Laborer

9-BIRTHPLACE

(State or country)

MD

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER
(State or country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Julia Gail

(Address)

925 Morris St

MAY 21 1915

Filed

, 191

MARY O. ABLEWS,
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

May 20th 1915

17. I HEREBY CERTIFY, That I attended deceased from

Dec 20, 1914, to May 18, 1915.

that I saw him alive on May 18, 1915.

and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous
Nephritis

(Duration) 04 yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) D. G. Garrett M. D.
May 19th 1915 (Address) 354 W. Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

National Cem

May 21, 1915

20-UNDERTAKER

ADDRESS

Samuel S. Newby 578 W. Biddle St

E85485

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

E85485

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8)

2-FULL NAME

(Residence in Baltimore: No.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

May

24, 1872

7-AGE

43

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Post-master

9-BIRTHPLACE
(State or country)

md.

10-NAME OF FATHER

Stephen Bowdoin

11-BIRTHPLACE OF FATHER
(State or country)

md.

12-MAIDEN NAME OF MOTHER

Anne Townsend

13-BIRTHPLACE OF MOTHER
(State or country)

md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Phelps.
John Hopkins Hosp.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

20

1913

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That, I attended deceased from
May 14, 1913, to, May 20, 1913

that I saw him alive on May 20, 1913, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral neoplasm, degenerative

(Duration) 3 yrs. mos. ds.

Contributory
(SECONDARY)

Bronchopneumonia

(Duration) 7 yrs. mos. ds.

May 21, 1913 (Address) John Hopkins Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death, 6 yrs. mos. ds. In the 43 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

College Park, Md.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

College Park, Md.

May 22, 1913

20-UNDERTAKER

ADDRESS

W. S. Tickner, North Park

MAY 22 1915

J. O. ANDREWS,
Burial Permit Clerk
REGISTRAR

10. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85486

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85486

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3713 Parkbrights Ave.* WARD *15*)

2-FULL NAME

(Residence in Baltimore: No. *3713 Parkbrights Ave.* St. *50* yrs., — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female white

4-COLOR OR RACE,

London
6-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Jan 20th 1848
(Month) (Day) (Year)

7-AGE,

67 yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Paris France

10-NAME OF FATHER,

John Freeman

11-BIRTHPLACE OF FATHER (State or Country),

Paris France

12-MAIDEN NAME OF MOTHER

Marianne Sumner

13-BIRTHPLACE OF MOTHER (State or Country),

France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant)

(Address)

Mrs. Howard C. Phillips
*3713 Parkbrights Ave.**Harry O. Allen**Serial Permit Clerk*

Registrar.

Filed

191

Dr. J. S. Jeffers, 442 N. Carrollton

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 20th 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

May 1 1915, to *May 20 1915*,that I saw her alive on *May 20 1915*,and that death occurred, on the date stated above, at *8:30 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis
Left Hemiplegia
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *J. S. Jeffers* M. D.*May 20, 1915* (Address) *442 N. Carrollton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

May 24, 1915

20-UNDERTAKER

G. F. Walker

ADDRESS

723 W. ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85487

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85487

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. 7* ST. *7* WARD)

2-FULL NAME

Frank Land

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. *Pataasco Md*

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

*Mar**15**1**?*

(Month)

(Day)

(Year)

7-AGE

52

yrs.

mos.

ds.

or

min.?

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Laborer*9-BIRTHPLACE
(State or country)*Va.*

PARENTS

10-NAME OF FATHER

*Unknown*11-BIRTHPLACE OF FATHER
(State or country)*Unknown*

12-MAIDEN NAME OF MOTHER

*Amy ?*13-BIRTHPLACE OF MOTHER
(State or country)*Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Asberry

(Address)

7 & Prop.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*May**19**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 15, 191*5*, to *May 19*, 191*5*,that I saw him alive on *May 17*, 191*5*,and that death occurred, on the date stated above, at *4 P*.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration)

yrs.

6

ds.

Contributory
(SECONDARY)*Aortic insufficiency*

(Duration)

yrs.

mos.

ds.

(Signed),

Stanley B. Jones

M. D.

May 20, 191*5* [Address] *7 & Prop.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Pataasco Md

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Asbury Cem**May 22, 1915*

20-UNDERTAKER

ADDRESS

Harry A. Godfrey 1725 Orleans St

MAY 22 1915

Filed....., 191

B. KRAUTER,
Burial Permit Clerk

REGISTRAR

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

16-15. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85488

C85488

CERTIFICATE OF DEATH

1 PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C.

CITY OF BALTIMORE: (No.

St.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John George

(Residence in Baltimore: No.

Little Sisters of the Poor

St.:

Yrs.

Mos.

Ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

July

14

1834

7-AGE

50

Yrs.

Mos.

Ds.

If LESS than 1 day, Hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Mary Land

10-NAME OF FATHER

James B. George

11-BIRTHPLACE OF FATHER (State or country)

Not Known

12-MAIDEN NAME OF MOTHER

May E. Steward

13-BIRTHPLACE OF MOTHER (State or country)

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lester Benedict

(Address)

Little Sisters of the Poor

MAY 22 1915

ROBERT KRAUTER,

Filed

191

Serial 10000

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 21

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

No record

191

191

that I saw him alive on *no record* 191 and that death occurred, on the date stated above, at *11:55 P.* m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Unknown

(Duration)

Yrs.

Mos.

Ds.

Contributory (SECONDARY)

(Duration)

Yrs.

Mos.

Ds.

(Signed)

F. A. Warner

M. D.

May 21

1915

(Address)

1133 Valley St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

1 yrs.

2 mos.

In the

State

Yrs.

Mos.

Ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Green Mount Ch.

DATE OF BURIAL

May 22 1915

20-UNDERTAKER

Stewart & Mowen Co

ADDRESS

108 N. 7th St.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085489 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175085489

PLACE OF DEATH

CITY OF BALTIMORE (No. *St Josephs Hospital* ST.: *4*)

2-FULL NAME *Edgar H Lytle*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *727 N Saratoga*

St.: yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)

6-DATE OF BIRTH, *Aug 9th*, 18*77* (Month) (Day) (Year)

7-AGE, *37* yrs. *9* mos. *11* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Carpenter* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Ind*

10-NAME OF FATHER, *Nicholas R Lytle*

11-BIRTHPLACE OF FATHER (State or Country), *Ind*

12-MAIDEN NAME OF MOTHER, *Amanda Hughes*

13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annie Lytle*

(Address) *236 N Carey St*

15-*ROBERT KRAUTER,* MAY 22 1915, *Corial Permit Clerk* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 20th*, 191*5* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquiry* (Inquest, au- topsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows: *Ruptured Liver*

(Duration) ... yrs. ... mos. ... ds. CONTRIBUTORY *Motorcycle Accident* (Secondary)

(Signed) *William V Russell* M. D. (Coroner.) *May 20th*, 191*5* (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *White Hall mch* DATE OF BURIAL, *May 23 1915*

20-UNDERTAKER, *Wilbur H Shriver* ADDRESS, *1712 Fulton Ave*

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85490

CERTIFICATE OF DEATH

151 C85490

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1234 Short Alley ST.: 5 WARD)

2-FULL NAME Baby Berry

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

(Residence in Baltimore: No. 1234 Short Alley St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE Black 5-SINGLE single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH May 30, 1915
(Month) (Day) (Year)

7-AGE If LESS than 1 day, hrs.
..... yrs. mos. ds. or min.?

8-OCCUPATION none
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Ind

10-NAME OF FATHER Joe Bolden

11-BIRTHPLACE OF FATHER (State or country) Ind

12-MAIDEN NAME OF MOTHER Ella Berry

13-BIRTHPLACE OF MOTHER (State or country) Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Berry

(Address) 1234 Short Al.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20, 1915, to May 21, 1915, that I saw her alive on May 20, 1915, and that death occurred, on the date stated above, at 8.4 m. The CAUSE OF DEATH* was as follows:

Prematurity
8 mos. fetus

(Duration) yrs. mos. ds.
Contributory (SECONDARY) Atelectasis

(Signed) E. D. Plasi M. D.
May 21, 1915 [Address] J. H. H.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paul. Cemetery

May 22, 1915

20-UNDERTAKER

ADDRESS

Robt. O. Smith

564 Madison Ave.

15-MAY 22 1915

Filed 191

ROBERT KRAUTER

Serial Permit Clerk

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85491

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 C85491

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 2027 W. Tawale.

St. 16 WARD)

2-FULL NAME Peter Thomas Pilchard

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

(Residence in Baltimore: No. 2027 W. Tawale St. Sr. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6-DATE OF BIRTH Aug 20, 1835 (Month) (Day) (Year)

7-AGE 79 yrs. 8 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Retired Farmer (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Md.

10-NAME OF FATHER Thomas Pilchard

11-BIRTHPLACE OF FATHER (State or country) Md.

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Wally A. Pilchard

(Address) 2027 W. Tawale

15-MAY 22 1915 ROBERT KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 19, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1914, to May 19, 1915, that I saw him alive on May 19, 1915, and that death occurred, on the date stated above, at 4 P. m. The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

Contributory (SECONDARY)

(Signed) M. J. Jones M. D. May 20, 1915 (Address) 1235 W. Lafayette Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pocomoke City Md. May 22, 1915

20-UNDERTAKER ADDRESS

W. W. Moulton 230 N. Greene

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85492

CERTIFICATE OF DEATH.

74 C85492

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *1* WARD)2-FULL NAME *Dorothea Purich*(Residence in Baltimore: No. *2207 Orleans St.* St.: yrs. mos. da.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

6-DATE OF BIRTH *June 20, 1866*7-AGE *53* yrs. *11* mos. *0* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *General*

9-BIRTHPLACE,

(State or Country), *Md.*10-NAME OF FATHER *John Purich*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Louise Rudolph*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mercy Hospital*(Address) *2207 Orleans St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 21, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Mar. 28, 1915*, to *May 21, 1915*,that I saw her alive on *May 21, 1915*, and that death occurred, on the date stated above, at *3:59* p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor
(Duration) *Don't know* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) *Don't know* yrs. mos. ds.
(Signed) *Edw. St. Smith* M. D.
May 21, 1915 (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* mos. *22* ds. In the *City* State *Md.* yrs. mos. ds.Where was disease contracted if not at place of death? *2207 Orleans St.*Former or usual residence *2207 Orleans St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL, *May 24, 1915*20-UNDERTAKER *Geo M. Fink*ADDRESS *811 N. Wood*

15-

MAY 22 1915 ROBERT KRAUTER, Registrar
Burial Permit Office

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85493

CERTIFICATE OF DEATH.

92
REGISTERED No. C

C85493

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 N. Charles

ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Edward Gartside

(Residence in Baltimore: No.

2212 N. Charles

St.; 6 yrs., 2 mos. 13 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

February 22, 1909
(Month) (Day) (Year)

7-AGE,

6 yrs., 2 mos., 13 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Joseph Gartside

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Corinne Sanders

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Anna F. Sanders

(Address)

2212 N. Charles St.

15-

MAY 22 1915

HARRY O. ATKINS,

Filed

191

Serial 1211-1212

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 20, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 15 1915, to May 20 1915,

that I saw him alive on May 19 1915,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY

(Secondary)

ing +) Hypertension

(Duration) ... yrs. ... mos. ... ds.

(Signed)

Geo. P. Kemp

M. D.

May 21, 1915 (Address) 8 W 25th St

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Greenmount Cemetery

DATE OF BURIAL,

5/22, 1915

20-UNDERTAKER

Henry W. Williams & Son

ADDRESS

555 N. Calvert St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.;

WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. (ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 22 1915

LARRY O. ANDREWS,

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 14 1915, to May 20 1915, that I saw him alive on May 20 1915, and that death occurred, on the date stated above, at 11:45 P.m. The CAUSE OF DEATH* was as follows:

Acute Broncho pneumonia

(Duration) yrs. mos. (ds.)

CONTRIBUTORY Cause of death

(Secondary)

(Duration) yrs. mos. (ds.)

(Signed) J. S. Sprague M. D.

May 21, 1915. (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. (ds.) In the State yrs. mos. (ds.)

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

29-UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Q85497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

Q85497

PLACE OF DEATH

CITY OF BALTIMORE (No. 1009 N. Fulton Ave. ST. 16 WARD)

FULL NAME Richard Hackett

(Residence in Baltimore: No. 1009 N. Fulton Ave. St. 73 yrs. 3 mos. 20 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 17.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6. DATE OF BIRTH

January 29, 1842
(Month) (Day) (Year)

7. AGE

73 yrs. 3 mos. 20 ds.
or—min.?

IF LESS than

1 day, hrs.

or—min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Carpenter (Retired)
B & O R. R. Co.

9. BIRTHPLACE

(State or country)

Baltimore

10. NAME OF FATHER

Michael Hackett

11. BIRTHPLACE OF FATHER

(State or country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Orlocker

13. BIRTHPLACE OF MOTHER

(State or country)

Ellicott City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Richard R. Hackett

(Address)

1009 N. Fulton Ave.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 19, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1914, to, May 19, 1915,

that I saw him alive on May 18, 1915,

and that death occurred, on the date stated above, at 2:35 a.m.

The CAUSE OF DEATH* was as follows:

(Clinical Diagnosis)
Cancer of stomach

(Duration) 1 yr. 10 mos. 2 ds.

Contributory Cause of death
(SECONDARY)

(Duration) yrs. 2 mos. 2 ds.

(Signed) J. Frederick Lutz, M.D.
May 19, 1915 (Address) 2040 Euterpe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

London Park Cem.

DATE OF BURIAL

May 22, 1915

20. UNDERTAKER

W. B. Brothers

ADDRESS

27 N. Fulton Ave.

15. MAY 22 1915

Filed

191

HARRY O. ADAMS,

Serial Permit Clerk

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Q85498

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Q85498

1 PLACE OF DEATH
CITY OF BALTIMORE: (No. **838** Harford Ave. ST. **10** WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME **Margarette E. Adam,**
(Residence in Baltimore: No. **838** Harford AVE. St.; **15** yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX **female** 4-COLOR OR RACE **white** 5-SINGLE **married**
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
6-DATE OF BIRTH **July 21, 1851**
(Month) (Day) (Year)
7-AGE **62** yrs. **10** mos. ds. or min.?
If LESS than 1 day, hrs., min.?
8-OCCUPATION
(a) Trade, profession or particular kind of work **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer) **-----**
9-BIRTHPLACE (State or country) **Baltimore Co. Md.**

PARENTS

10-NAME OF FATHER **Andrew Doyle**
11-BIRTHPLACE OF FATHER (State or country) **Ireland.**
12-MAIDEN NAME OF MOTHER **Not known**
13-BIRTHPLACE OF MOTHER (State or country) **Not known**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Wm. Neilrain, O Adam**
(Address) **838 Harford Ave**

15-MAY 22 1915

Wm. O. ADAMS,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from **May 20, 1915**, to **May 21, 1915**, that I saw her alive on **May 21, 1915**, and that death occurred, on the date stated above, at **m.** The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) yrs mos. ds.
Contributory (SECONDARY) **Arteriosclerosis.**
(Duration) **8** yrs mos. ds.
(Signed) **John S. Hark** M. D.
May 21, 1915 [Address] **936 E. Monument St**

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery

May 24, 1915

20-UNDERTAKER

ADDRESS

Henry Horch Sen

1301 E. Bay St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1-PLACE OF DEATH *St Elizabeth House*
CITY OF BALTIMORE: (No. *2*) WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)
2-FULL NAME *Elsie Randolph*
(Residence in Baltimore: No. *St Paul St* St; *5* yrs. *5* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *colored* 5-SINGLE *Single*
6-DATE OF BIRTH *Dec 2, 1914*
7-AGE *5* yrs. *5* mos. *5* ds. or *1* day, *5* hrs., *5* min.?
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE (State or country) *Baltimore*
10-NAME OF FATHER *L.*
11-BIRTHPLACE OF FATHER (State or country) *2*
12-MAIDEN NAME OF MOTHER *2*
13-BIRTHPLACE OF MOTHER (State or country) *2*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 19, 1915*
17-I HEREBY CERTIFY, That I attended deceased from *March 8, 1915*, to, *May 19, 1915*, that I saw her alive on *May 19, 1915*, and that death occurred, on the date stated above, at *1* p.m.
The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration) *5* yrs. *5* mos. *5* ds.
Contributory (SECONDARY) *Infection*
(Signed) *Eleanor S. Fiedelwald* M.D.
May 20, 1915 [Address] *1610 Linden Ave*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death *5* yrs. *5* mos. *5* ds. In the State *5* yrs. *5* mos. *5* ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *UNIVERSITY OF MARYLAND* DATE OF BURIAL *MAY 22 1915*

BURIAL PERMIT NO. *1* ADDRESS
FOR ANATOMICAL PURPOSES

MAY 22 1915

UNIVERSITY OF MARYLAND
REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085500

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45

085500

1. PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1111 W. Laurels St. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME

William Litz (Litz)

(Residence in Baltimore: No. 1111 W. Laurels St. Sr.: 63 yrs. 7 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (Write the word)

6. DATE OF BIRTH September 23, 1851 (Month) (Day) (Year)

7. AGE 63 yrs. 7 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work Photographer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country)

Balto. Md.

10. NAME OF FATHER

Charles S. Litz

PARENTS

11. BIRTHPLACE OF FATHER (State or country)

Lancaster, Pa.

12. MAIDEN NAME OF MOTHER

Sophia Theresa Sommer

13. BIRTHPLACE OF MOTHER (State or country)

Lancaster, Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Litz, M.D.

(Address)

1111 W. Laurels St.

15.

MAY 22 1915

CARRY O. ADAMS

BURIAL PERMIT CLERK

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 21, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3, 1914, to May 21, 1915,

that I saw him alive on May 21, 1915, and that death occurred, on the date stated above, at 6:20 p.m. The CAUSE OF DEATH* was as follows:

Carcinoma of the Larynx (Clinical Diagnosis)
(Duration) — yrs. 11 mos. — ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Charles Litz M. D.
May 21, 1915 (Address) 1111 W. Laurels St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wood Ridge Cemetery

May 23, 1915

20. UNDERTAKER

ADDRESS

George J. Smith

702 E. St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

085501

64 085501

PLACE OF DEATH

CITY OF BALTIMORE (No. 2322 McCulloh

St. 13 WARD)

2-FULL NAME Susan C. Cony

Residence in Baltimore: No. 2322 McCulloh

St. 40 yrs. — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widow

6-DATE OF BIRTH Sept —, 1839 (Month) (Day) (Year)

7-AGE 75 yrs. 8 mos. — ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE (State or country) Massachusetts

10-NAME OF FATHER — Beck

11-BIRTHPLACE OF FATHER (State or country) Massachusetts

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or country) Massachusetts

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harriet Berryman

(Address) 2322 McCulloh

15-MAY 22 1915, HARRY O. ATHERTON, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 21st, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 20th, 1915, to May 21st, 1915, that I saw him alive on May 21st, 1915, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Contributory (SECONDARY) Arterio sclerosis (Duration) — yrs. — mos. 2 ds.

(Signed) Eugene Douglas M. D. 5-21st, 1915 (Address) 830 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Long Bridge on May 22, 1915

20-UNDERTAKER ADDRESS

W. L. Richards Remax North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85502

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37 C85502
REGISTERED No. C.....

1-PLACE OF DEATH
2-CITY OF BALTIMORE: (No. *8*) *Johns Hopkins Hosp.* ST. *17* WARD
3-FULL NAME *Baby Baker*
4-RESIDENCE IN BALTIMORE: No. *1311 Division St.* St.; *17* yrs. *20* mos. *5* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

5-SEX *male* 6-COLOR OR RACE *Black* 7-SINGLE *Single*
8-DATE OF BIRTH *April 20, 1915*
9-AGE *3 wks.* If LESS than 1 day, *1* day, *1* hrs., *1* min.
10-OCCUPATION *none*
11-BIRTHPLACE *md.*

PARENTS

12-NAME OF FATHER *Wm. Baker*
13-BIRTHPLACE OF FATHER *Va.*
14-MAIDEN NAME OF MOTHER *Mary*
15-BIRTHPLACE OF MOTHER *Va.*

16-THIS ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MAY 22 1915

HENRY O. JOHNS
Serial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 20, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *May 21, 1915*, to *May 20, 1915*, that I saw him alive on *May 20, 1915*, and that death occurred, on the date stated above, at *11:40* pm.
The CAUSE OF DEATH* was as follows:

Congenital Syphilis

Contributory (SECONDARY) *Bleeding*
(Duration) *21* yrs. *5* mos. *5* ds.
(Signed) *Alvin S. Rollins* M.D.
May 21, 1915 (Address) *Johns Hopkins Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *1* yrs. *3* mos. *3* ds. State *1301 Division St.*
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *HOPKINS HOSPITAL* DATE OF BURIAL *MAY 21 1915*

FOR ANATOMICAL PURPOSES

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Q85503

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 Q85503

CERTIFICATE OF DEATH

1 PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *23* WARD)
2-FULL NAME *Beatrice Harris*
Residence in Baltimore: No. *159 Hamburg St.* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Black* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Single*

6-DATE OF BIRTH *May 1, 1915*
(Month) (Day) (Year)

7-AGE *3 wks.* If LESS than 1 day, hrs. yrs. mos. ds. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) *None*

9-BIRTHPLACE (State or country) *md.*

PARENTS
10-NAME OF FATHER *Lucius Harris*
11-BIRTHPLACE OF FATHER (State or country) *md.*
12-MAIDEN NAME OF MOTHER *Susan Bryan*
13-BIRTHPLACE OF MOTHER (State or country) *md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. Phelps*

(Address) *Johns Hopkins Hosp.*

MAY 22 1915

Filed

191

Harry O. Johns

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 21, 1915*
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from *May 19, 1915* to *May 21, 1915* that I saw him alive on *May 21, 1915* and that death occurred, on the date stated above, at *2* m. The CAUSE OF DEATH* was as follows:
Prematurity

Contributory (SECONDARY)

(Signed) *Oliver S. Rotch* M. D.
May 21, 1915 [Address] *J. H. Hop.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *2* In the State yrs. mos. *3 wks.*

Where was disease contracted, if not at place of death?

Former or usual residence *159 Hamburg St.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

HARRY O. JOHNS HOPKINS HOSPITAL

MAY 21 1915

20-UNDERTAKER

ADDRESS

FOR ANATOMICAL PURPOSES

085504

HEALTH DEPARTMENT—CITY OF BALTIMORE

085504

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2914 Hudson* ST. *1* WARD)FULL NAME *Mrs Teofilia Gackowska*(Residence in Baltimore: No. *2914 Hudson* St. *31* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, *married* WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *Unknown*, 1853 (Month) (Day) (Year)7-AGE *62* yrs. mos. ds. 11-LESS than 1 day. hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *House wife* (b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country) *Germany*10-NAME OF FATHER, *Matthias Lubinski*11-BIRTHPLACE OF FATHER, (State or Country) *Germany*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER, (State or Country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thomas Gackowski*(Address) *2914 Hudson*

15-

MAY 22, 1915.

HARRY O. JEFFERS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 21*, 1915 (Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *May 1*, 1915, to *May 21*, 1915, that I saw her alive on *May 18*, 1915, and that death occurred, on the date stated above, at *5 P. m.*

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs. mos. ds.(Signed) *A. B. Tullow* M. D. *May 22*, 1915. (Address) *3035 Odumell*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaw

DATE OF BURIAL,

May 24, 1915

20-UNDERTAKER

M. J. Gackowski

ADDRESS

705 S. Ave. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

085505

CERTIFICATE OF DEATH.

x 170

085505

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Saint Josephs Hospital* ST.: *9* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Hardings Va* St.: yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *Nov. 9, 1861*
(Month) (Day) (Year)

7-AGE, *53* yrs., *6* mos., *11* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Hardings Va*

10-NAME OF FATHER, *Lucien Hardings*

11-BIRTHPLACE OF FATHER (State or Country), *Va*

12-MAIDEN NAME OF MOTHER, *Addie Corbin*

13-BIRTHPLACE OF MOTHER (State or Country), *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Me. Rozz Hardings*.....

(Address) *Hardings Va*.....

15-MAY 22 1915 HENRY O. ANDREWS, Registrar.

Filed..... 191. *1st Permt 0101*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 21, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 8* 1915, to *May 21* 1915, that I saw him alive on *May 21* 1915, and that death occurred, on the date stated above, at *6:30 P.m.* The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis
(Duration)..... yrs., mos., ds.

CONTRIBUTORY (Secondary) *Hypostatic Pneumonia*

(Signed) *J. J. Warner* M. D.
May 21, 1915 (Address) *Saint Josephs Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., *13* ds. In the State yrs., mos., *13* ds.

Where was disease contracted, if not at place of death? *Hardings Va*

Former or usual residence *Hardings Va*

19-PLACE OF BURIAL OR REMOVAL, *Mila Northumberland Co*

DATE OF BURIAL, *May 23, 1915*

20-UNDERTAKER *Ed Manning* 1938 & *Safayette a*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085506

HEALTH DEPARTMENT—CITY OF BALTIMORE

085506

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2314 Eager Place* ST. *7* WARD)

REGISTERED NO. C.

2-FULL NAME

(Residence in Baltimore: No. *2314 Eager Place* St.: *17* yrs., *6* mos., *12* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH

November 9, 1897
(Month) (Day) (Year)

7-AGE,

17 yrs., *6* mos., *12* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),*Baltimore Md.*

10-NAME OF FATHER,

*Julius Bohlofink*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore Md.*

12-MAIDEN NAME OF MOTHER

*Amelia Sargable*13-BIRTHPLACE OF MOTHER
(State or Country),*Aberdeen Harbor Co. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Baker*(Address) *2314 E. Eager Street*

15-

MAY 22 1915

Filed..... 191...
Special Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 21, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 19* 1915, to *May 20* 1915, that I saw her alive on *May 20* 1915, and that death occurred, on the date stated above, at *7:20 P. M.*

The CAUSE OF DEATH* was as follows:

Cerebro. of mal meningitis.

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY... *Pneumo. pneumonia*
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) *Frank J. [Signature]* M. D.*May 21, 1915* (Address) *9937 E. Monument St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Carmel Cemetery

DATE OF BURIAL,

May 24, 1915

20-UNDERTAKER

Christian Miller

ADDRESS

2334 Jefferson St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085507 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Sudlow ST. 24 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1611 Sudlow St. 24 yrs. 3 mos. 14 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Widow

6-DATE OF BIRTH.

Feb 7, 1841
(Month) (Day) (Year)

7-AGE.

74 yrs. 3 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed MAY 22 1915 HARRY O. ANDREWS,
Marial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 5 1915, to May 21 1915,that I saw her alive on May 21 1915,and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute pneumonia
Barrocha pneumonia
(Duration)..... yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. 16 ds.
(Signed)..... M. D.
May 22, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Cedar Hill May 24, 1915

20-UNDERTAKER

ADDRESS

William Cook 502 N. Main

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085508

HEALTH DEPARTMENT—CITY OF BALTIMORE

085508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *612 W Conway* ST. *22* WARD)

2-FULL NAME *August Langlotz*

(Residence in Baltimore: No. *612 W Conway* St.; yrs. *7* mos. *17* da.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*

4-COLOR OR RACE *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH, *Aug 11*, 1887

(Month)

(Day)

(Year)

7-AGE, *57* yrs. *9* mos. *17* da.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Cigar maker*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balto*

PARENTS.

10-NAME OF FATHER, *Wm C Langlotz*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *Henrietta Kern*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Mary McMurtry*

(Address) *612 W Conway*

15-

MAY 22 1915

HENRY O. ADAMS,

1915 Burial Permit. Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 21*, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to *his* death topsy or inquiry on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis
(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) *Chr. hepatitis*

(Duration) ... yrs. ... mos. ... da.

(Signed) *J. D. Jeffers* M. D.

(Coroner.) *May 21*, 1915 (Address) *1115 N. Carrollton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. da. In the State.... yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Baltimore*

DATE OF BURIAL, *5/23*, 1915

20-UNDERTAKER, *McCann Corp*

ADDRESS, *301 E. North*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085509

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

Residence in Baltimore: No.

ST. 13 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 61 yrs. 6 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married
6-DATE OF BIRTH Nov 21, 1853 (Month) (Day) (Year)		
7-AGE 61 yrs. 6 mos. — ds. If LESS than 1 day, — hrs. or — min. 7		
8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housewife		
9-BIRTHPLACE (State or country) Baltimore Ind		
PARENTS	10-NAME OF FATHER Charles Burton	
	11-BIRTHPLACE OF FATHER (State or country) Balto. Co. Ind	
	12-MAIDEN NAME OF MOTHER Eliza Clarke Grace	
	13-BIRTHPLACE OF MOTHER (State or country) Balto. Co. Ind	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

MAY 22 1915

191

HARRY O. ALLEN

Serial Permit Officer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 21, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 9, 1915, to May 21, 1915
that I saw her alive on May 20, 1915

and that death occurred, on the date stated above, at 6:10 a.m.

The CAUSE OF DEATH* was as follows:

Indigestion
Carcinoma
(Clinical Diagnosis)
(Duration) 6 mos. 6 wks
Contributory Mammary Carcinoma
(SECONDARY) (Microscopic diagnosis)
(Duration) 1 yrs. 6 mos. 6 wks
(Signed) H. H. Stevenson M. D.
May 21, 1915 (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

LOUDON PARK

DATE OF BURIAL

MAY 23 1915

20-UNDERTAKER

ARMSTRONG-DENNY CO.

ADDRESS

715 Light St

HEALTH DEPARTMENT-CITY OF BALTIMORE

85510

61 85510

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1111 Peach Alley* ST. *23* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1111 Peach Alley* St. *8* yrs. *13* mos. *13* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Female</i>	4-COLOR OR RACE <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <i>Single</i>
6-DATE OF BIRTH <i>Sept. 8, 1914</i> (Month) (Day) (Year)		
7-AGE <i>8</i> yrs. <i>13</i> mos. <i>13</i> ds. If LESS than 1 day, ...hrs. or...min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <i>None</i>		
9-BIRTHPLACE, (State or Country) <i>Baltimore, Md.</i>		
PARENTS.	10-NAME OF FATHER <i>Lawrence Meyers</i>	
	11-BIRTHPLACE OF FATHER (State or Country) <i>Baltimore</i>	
	12-MAIDEN NAME OF MOTHER <i>Luna Krasner</i>	
	13-BIRTHPLACE OF MOTHER (State or Country) <i>Baltimore</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lawrence Meyers*
(Address) *1111 Peach Alley*

15-*MAY 22 1915* HARRY O. ANDREWS,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 21, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 9* 1915, to *May 21* 1915, that I saw her alive on *May 21*, 1915, and that death occurred, on the date stated above, at *1 P* m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis
(Duration) ... yrs. ... mos. *11* ds.
CONTRIBUTORY (Secondary) *Paralysis (Cardiac & Respiratory)*
(Duration) ... yrs. ... mos. *1* hr.
(Signed) *J. M. Dilevett* M. D.
May 21, 1915 (Address) *621 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Baltimore, Md. DATE OF BURIAL, *May 22, 1915*

20-UNDERTAKER.

John D. Cook ADDRESS *1003 N. E. St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

085511

CERTIFICATE OF DEATH.

085511

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1729 E. Lafayette av.* ; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Minnie Holland*(Residence in Baltimore: No. *1729 E. Lafayette av.*)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)6-DATE OF BIRTH, *Jan 14*, 18*75*
(Month) (Day) (Year)7-AGE, *40* yrs. *4* mos. *7* ds. If LESS than 1 day, hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Samuel Sunderland*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Minnie Haines*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William L. Holland*(Address) *1729 E. Lafayette Av.*15- *MAY 22 1915* HARRY O. ANDREWS,Filed *191* *Marial Permit Olax* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 21*, 19*15*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 10* 1915, to *May 21*, 1915, that I saw her alive on *May 21*, 1915, and that death occurred, on the date stated above, at *8:30 p.m.* The CAUSE OF DEATH* was as follows:*Bright's disease*(Duration) *1* yrs. *Probably*

CONTRIBUTORY (Secondary).....

(Duration)..... yrs. mos. ds.

(Signed) *Edwin B. Finby, M. D.**May 22* 1915. (Address) *1223 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Louden Park Cemetery* DATE OF BURIAL, *May 24*, 1915.20-UNDERTAKER *Joe B. Cook* ADDRESS *1003 W. Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155 085512

PLACE OF DEATH
CITY OF BALTIMORE (No. *21 S. Lloyd*)
FULL NAME *David Weizman*
(Residence in Baltimore: No. *102 S. Caroline*)

ST.: *3* WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St.: *yr.* *6* mos. *da.*

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
4-COLOR OR RACE, *white*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)
6-DATE OF BIRTH, *April 20, 1895*
(Month) (Day) (Year)
7-AGE, *20* yrs. *1* mos. *2* ds.
IF LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Clothing Cutter*
(b) General nature of industry, business, or establishment in which employed (or employer), *A. J. Strauss & Co.*

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, *England*
Meyer Weizman
11-BIRTHPLACE OF FATHER (State or Country), *Russia*
12-MAIDEN NAME OF MOTHER, *Rebecca Abraham*
13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Meyer Weizman*
(Address) *21 S. Lloyd St.*

15-
MAY 23 1915
HARRY O. ANLBENS,
Bureau Permit Officer
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 22nd, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)
find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bi-Chloride of Mercury Poison
Taken May 16, 1915
Probably suicidal
(Duration) *1* yrs. *1* mos. *6* ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs. *1* mos. *6* ds.
(Signed) *David W. Jones* M. D.
(Coroner.)
May 22 1915 (Address) *316 E. Carroll St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death, ... yrs. ... mos. ... ds. State, ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Alfred Roadside
20-UNDERTAKER
Lincoln & Co. Balto St.

DATE OF BURIAL,

May 23 1915
ADDRESS *11078*

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

085513

HEALTH DEPARTMENT--CITY OF BALTIMORE

085513

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

121 N Bond

ST.

6

WARD)

2 FULL NAME

Fannie Bernau

(Residence in Baltimore: No.

121 N Bond

St.: 20 yrs.

mos.

ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

Apr/Nov, 1

(Month)

(Day)

(Year)

7 AGE

70

yrs.

mos.

ds.

If LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Russia

10 NAME OF FATHER

John Sandler

11 BIRTHPLACE OF FATHER (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. Bernau

(Address)

121 N Bond St

15

MAY 23 1915

HARRY O. ANDREWS,

Serial Peralt Olav

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May

21

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 14

1915

to,

May 21

1915

that I saw him alive on May 21, 1915,

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Gastrointestinal catarrh

(Duration) yrs.

mos.

ds.

Contributory (SECONDARY)

Pulmonary congestion

(Duration) yrs.

mos.

ds.

(Signed),

John Sandler

M. D.

May 22, 1915

(Address)

20 E. Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Subw Rosedale

DATE OF BURIAL

May 23, 1915

20 UNDERTAKER

J. L. Linnson & Co.

ADDRESS

1107 E

Balto St

HEALTH DEPARTMENT—CITY OF BALTIMORE

085514

CERTIFICATE OF DEATH.

187 085514

1-PLACE OF DEATH

CITY OF BALTIMORE; No. 428 Moore

ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lavinia Roberts

(Residence in Baltimore: No. 428 Moore

St.; 31 yrs., 8 mos., 11 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. Cal. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)

6-DATE OF BIRTH. Sept - 9th, 1883 (Month) (Day) (Year)

7-AGE. 31 yrs., 8 mos., 11 da. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Domestic (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Baltimore City

10-NAME OF FATHER. Williams Hawkins

11-BIRTHPLACE OF FATHER (State or Country). Virginia Va.

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Robert Hubbard

(Address) 428 Moore St.

15- MAY 23 1915 HARRY O. ANTHONY, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. May - 20, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 19 1915, to May 20 1915, that I saw her alive on May 18 1915, and that death occurred, on the date stated above, at 8 A. M. The CAUSE OF DEATH* was as follows:

Complications of Disease - Dropsy (Duration) 6 mos.

CONTRIBUTORY. Excessive Dropsy (Secondary) (Duration) 6 mos.

(Signed) Samuel A. Kean M. D.

May 20, 1915 (Address) 937 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, May 23 1915

20-UNDERTAKER John H. Foadwin ADDRESS 142 W. 14th

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085515

HEALTH DEPARTMENT—CITY OF BALTIMORE

085515

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 834 Hamilton Terrace ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Mary Priscilla Gover

(Residence in Baltimore: No. 834 Hamilton Terrace St.; 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX,

4-COLOR OR RACE,

5-SINGLE, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH,

Mar 24th 1863

7-AGE,

32 yrs. 1 mos. 28 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Philip Gover

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Sarah Moores

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. L. ...

(Address) 834 Hamilton Terrace

MAY 23 1915

Filed ... Burial Permit ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 22, 1915

I HEREBY CERTIFY, That I attended deceased from May 1914, to May 22 1915, that I saw him alive on May 22 1915, and that death occurred, on the date stated above, at 3:10 P.M. The CAUSE OF DEATH* was as follows:

Cerebral Syncope

CONTRIBUTORY (Secondary)

(Signed) H. Robert K. ... M. D.
May 22, 1915. (Address) 1509 N. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Forest Hill, Md

DATE OF BURIAL,

May 24, 1915

20-UNDERTAKER

W. M. Gauthier

ADDRESS

1624 Mt. Royal Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

085516

167

085516

PLACE OF DEATH

CITY OF BALTIMORE (No. 1715 Hanover

ST. 23 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Carl G Discher

St. 1 yrs., 1 mos. 10 da.)

(Residence in Baltimore: No. 1715 Hanover

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male	4-COLOR OR RACE, Whiten	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)
6-DATE OF BIRTH, April 11, 1914 (Month) (Day) (Year)		
7-AGE, 1 yrs., 1 mos. 10 da.		If LESS than 1 day, ...hrs. or ...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work... None (b) General nature of industry, business, or establishment in which employed (or employer)...		

9-BIRTHPLACE, (State or Country), Balto Md	
PARENTS.	10-NAME OF FATHER, August M Discher
	11-BIRTHPLACE OF FATHER (State or Country), Balto Md
	12-MAIDEN NAME OF MOTHER Margaret Gale
	13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) **August Discher**
(Address) **1715 Hanover St**

15-**MAY 23 1915**
Filed **1915**
Harry O. Andrews,
Serial Permit Clerk,
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21, 1915 (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above. The CAUSE OF DEATH* was as follows: Accidental scald Pulled hot water from stove (Duration) ... yrs. ... mos. ... da. CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... da. (Signed) Edwin Scott M. D. (Coroner) May 22 1915. (Address) 517 Scott St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death... yrs. ... mos. ... da. In the State... yrs. ... mos. ... da.
Where was disease contracted, if not at place of death?
Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery	DATE OF BURIAL, May 23rd 1915
20-UNDERTAKER, C. Schlenker & Son	ADDRESS 1039 Hanover St

Q85517

HEALTH DEPARTMENT—CITY OF BALTIMORE

Q85517

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1167 Cleveland St. 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

George Volkmar(Residence in Baltimore: No. 1167 ClevelandSt.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH

Oct.

(Month)

4th, 1849

(Day)

(Year)

7-AGE.

65

yrs.

7

mos.

17

ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Noneat present

9-BIRTHPLACE,

(State or Country), Germany

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Volkmar(Address) 1167 Cleveland St.

MAY 23 1915

HARRY O. ANDREWS,

Filed..... 191.. Burial Permit Oliver Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 21, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

5-18-1915, to 5-21-1915,that I saw him alive on 5-21-1915,and that death occurred, on the date stated above, at 10 NT m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) John G. Selvensberg M. D.May 21 1915 (Address) 1170 W. Lewis

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Baltimore Cemetery May 24th, 1915.

20-UNDERTAKER

ADDRESS

Philip Seewald & Son 119 S. Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085518

HEALTH DEPARTMENT—CITY OF BALTIMORE

085518

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *St James Church Eagers Disquith* STS *9*)

2-FULL NAME *John F Moeller*

(Residence in Baltimore: No. *1424 Holbrook*)

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)

6-DATE OF BIRTH, *Jan 9, 1859* (Month) (Day) (Year)

7-AGE, *56* yrs. *4* mos. *13* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Tanner* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *Anton Moeller*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Sophia Jesteadt*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Ethelred Moeller*

(Address) *1424 Holbrook*

15-

MAY 23 1915

Marial Permit, Office

HARRY O. ANKERS

REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 22, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *Elijah J. Russell* M. D. (Coroner.) *May 22, 1915* (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer Cemetery*

DATE OF BURIAL, *May 25, 1915*

20-UNDERTAKER, *Henry Woodley*

ADDRESS *1301 E 34th St*

085519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108

085519

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.; *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *116 N. Street* St.; *1* yrs., *3* mos., *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED

Single
(Write the word.)

6-DATE OF BIRTH

Feb 8 1909
(Month) (Day) (Year)

7-AGE

*6 yrs. 3 mos. 14 ds.*If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Md.

10-NAME OF FATHER

James Klima

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Barbara Serley

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Information furnished by *Dr. J. M. Smith*)(Address) *Calvert St.*

15-

MAY 23 1915 HARRY O. ANDREWS,
Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 22 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *May 16 1915*, to *May 22 1915*, that I saw him alive on *May 22 1915*, and that death occurred, on the date stated above, at *5:45 P.M.*

The CAUSE OF DEATH* was as follows:

Sanguinous Appendicitis
about
(Duration) *9* hrs. *1* mo. *1* ds.

CONTRIBUTORY (Secondary)

General Peritonitis
(Duration) *7* hrs. *1* mo. *1* ds.
(Signed) *Edward D. Smith* M. D.
May 22 1915 (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *6* yrs. *3* mos. *14* ds. In the State *Life* yrs. *1* mo. *1* ds.Where was disease contracted, if not at place of death? *116 N. Street St.*Former or usual residence *116 N. Street St.*

19-PLACE OF BURIAL OR REMOVAL

Holy Redeemer Cemetery

DATE OF BURIAL

May 25 1915

20-UNDERTAKER

Henry Horck Sur

ADDRESS

130 E. 11th St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

~~85519~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~85519~~

85520

85520

CERTIFICATE OF DEATH.

64 85520

85520

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

814 Somerset

St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary E. Neuner

(Residence in Baltimore: No.

814 Somerset

St.; 34 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH.

November

4

1863

(Month)

(Day)

(Year)

7-AGE.

57

6

mos.

18

ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country).

Germany

10-NAME OF FATHER.

Bernard Stanger

11-BIRTHPLACE OF FATHER

(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country).

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Peter Neuner

(Address)

814 Somerset St.

15-

Filed

MAY 23 1915

HARRY O. ANDREWS,

Marial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 22

22

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 18, 1915, to May 22, 1915, that I saw her alive on May 21, 1915, and that death occurred, on the date stated above, at 6:40 m.

The CAUSE OF DEATH* was as follows:

Apoplectic Stroke

(Duration)

yrs.

mos.

4

ds.

CONTRIBUTORY (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. J. Seibert

M. D.

May 22, 1915.

(Address)

1201 R. R. 2nd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Redeemer

May 25, 1915.

20-UNDERTAKER

ADDRESS

Henry Horsch & Son

1301 E. Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85521

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85521

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 949 Franklin Road,

ST. 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Buckner,

(Residence in Baltimore: No. 949 Franklin Road,

St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female,

4-COLOR OR RACE,

Colored,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Widowed,

6-DATE OF BIRTH,

December 2, 1915.

(Month)

(Day)

(Year)

7-AGE,

81 yrs. 2 mos. 2 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None,

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Virginia,

10-NAME OF FATHER,

Oscar Carey,

11-BIRTHPLACE OF FATHER

(State or Country),

Virginia,

12-MAIDEN NAME OF MOTHER

Unknown,

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Buckner, daughter,

(Address) 949 Franklin Road.

MAY 23 1915

HARRY O. ANDREWS,

Filed, 1915 Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 20th, 1915.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to her death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably valvular heart disease.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick McCombs, M. D.

(Coroner.)

May 21, 1915 (Address) 3310 W. North Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Calvary Cem May 23 1915

20-UNDERTAKER

ADDRESS

Sam'l P. Kennedy 578 Middle

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85522

C85522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 E. Chae ST. 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1612 E. Chae St. 40 yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White5-SINGLE, Married,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Date of account Unknown, 1849
(Month) (Day) (Year)

7-AGE,

46 yrs. mos. ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work. Quilter
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer). Office Bldg.9-BIRTHPLACE,
(State or Country),Ireland10-NAME OF
FATHER,Joseph L.11-BIRTHPLACE
OF FATHER
(State or Country),Ireland12-MAIDEN NAME
OF MOTHER,Mary Kearney13-BIRTHPLACE
OF MOTHER
(State or Country),Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James J. Faulk(Address) 1225 W. 2nd St.

MAY 23 1915

HARRY G. ANDREWS,

Filed..... 191... Serial Permit O.L.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

3 20, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1913, to May 20 1915that I saw him alive on May 15 1915and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Ch. Enteroecosis
and Myocardial insuff.
(Duration).... yrs. mos. ds.CONTRIBUTORY
(Secondary)(Signed) E. J. Layman, M. D.
523, 1915 (Address) 836 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

May 24, 1915

20-UNDERTAKER

H. & M. S. Agnew

ADDRESS

1422 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85523

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85523

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *108 S Collington Ave* ST. WARD)

2-FULL NAME

(Residence in Baltimore: No. *108 S Collington* St.; *69* yrs., *11* mos., *11* da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) *Widowed*

6-DATE OF BIRTH

June 21st, 1845
(Month) (Day) (Year)

7-AGE

69 yrs., *11* mos., *11* da.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housework*9-BIRTHPLACE,
(State or Country).*Baltimore Md*

10-NAME OF FATHER

*Owen McDonald*11-BIRTHPLACE OF FATHER
(State or Country).*Ireland*

12-MAIDEN NAME OF MOTHER

*Ann Clarke*13-BIRTHPLACE OF MOTHER
(State or Country).*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward Herr*(Address) *108 S Collington Ave*

15-

MAY 23 1915 *HARRY O. ANDREWS*Filed....., 191... *Marial Permit* *Clay* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 21st, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jun 1* 1915, to *May 21* 1915,that I saw her alive on *May 20* 1915, and that death occurred, on the date stated above, at *830 a.m.*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(Duration) *5* yrs., *5* mos., *11* da.CONTRIBUTORY *Delayed heart*
(Secondary)(Duration) *1* yrs., *5* mos., *11* da.(Signed) *M. J. McCarver* M. D.*May 23 1915* (Address) *839 S. E. Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. da. In the State..... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

New Cathedral

DATE OF BURIAL

May 24, 1915

20-UNDERTAKER

John A. Moran

ADDRESS

Bank

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85524

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85524

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *522 S. Decker Ave* ST.: *1* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John Bowers*(Residence in Baltimore: No. *522 S. Decker Ave* St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *May 22, 1915*

(Month)

(Day)

(Year)

7-AGE, *13*

If LESS than 1 day.

13 hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country), *Maryland*10-NAME OF FATHER, *John Bowers*11-BIRTHPLACE OF FATHER, *Maryland*12-MAIDEN NAME OF MOTHER, *Olive Bowers*13-BIRTHPLACE OF MOTHER, *Maryland*

(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Bowers*(Address) *522 S. Decker Ave*

15-

MAY 23 1915

HARRY O. ANDREWS,

Filed

Vol.

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 23, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 22, 1915* to *May 23, 1915*.that I saw him alive on *May 22, 1915*, and that death occurred, on the date stated above, at *6:30 a.m.*

The CAUSE OF DEATH* was as follows:

7 month Foetus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. B. J. J. J.* M. D.*May 23, 1915* (Address) *3035 Odumville*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Stanislaw*DATE OF BURIAL, *May 24, 1915*

UNDERTAKER

ADDRESS

*M. J. Sadowski**705 S. Amst.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 C85526

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: No.

3904 Maine Ave. St. 15

WARD

2-FULL NAME

Amanda B May

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

3904 Maine Ave

St.; 10 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

widow

6-DATE OF BIRTH

Aug. 16, 1851

7-AGE

63 yrs. 9 mos. 6 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE

(State or country)

Wisconsin

PARENTS

10-NAME OF FATHER

Francis Bishop

11-BIRTHPLACE OF FATHER

Germany

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

German

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. W. Sebold

(Address)

3904 Maine Ave

MAY 28 1915

HARRY O. ANDREW

Marial Permit Clerk

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

May 22nd, 1915

17- I HEREBY CERTIFY, That I attended deceased from March, 1915, to May 22nd, 1915, that I saw her alive on May 22nd, 1915, and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage
(Clinical Diagnosis)

Contributory (SECONDARY)

Cancer of Stomach

(Signed)

Jas. H. Riedel

M. D.

May 28, 1915

[Address] Woodlawn and

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Waltersville

DATE OF BURIAL

May 24, 1915

20-UNDERTAKER

George J. Smith

ADDRESS

7000

C85527

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 C85527

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Hollins

ST.: 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah M. Brown

(Residence in Baltimore: No. 1602 Hollins

St.: 67 yrs., 1 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)

6-DATE OF BIRTH. April 15, 1848 (Month) (Day) (Year)

7-AGE. 67 yrs., 1 mos., 5 ds. If LESS than 1 day. hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

House

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

John M. Brown

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Sophie Bassil

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Kate Brown

(Address),

1602 Hollins St.

15-

MAY 23 1915

HARRY O. ANDREWS,

Burial Permitter

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 20, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1915, to May 20, 1915, that I saw her alive on May 19, 1915, and that death occurred, on the date stated above, at 11:00 m. The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 3 yrs., 3 mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed) S. M. Lempster M. D. May 22, 1915 (Address) 826 N. Carroll St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Druid Ridge Cem

DATE OF BURIAL,

May 23 1915

20-UNDERTAKER,

Wm. J. Tiekner & Sons

ADDRESS

425 W. Camden St.

N.B.—Every item of information should be carefully supplied. ACF should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

C85528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85528

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *3420 Mondawmin Ave* ST. *15* WARD) REGISTERED NO. C
2-FULL NAME *Anny L. Knirre*
(Residence in Baltimore: No. *3420 Mondawmin Ave*, St. *15* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)
6-DATE OF BIRTH, *March 26*, 18*86*
(Month) (Day) (Year)
7-AGE, *29* yrs., *1* mos., *26* ds. If LESS than 1 day, ...hrs. or...min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *at home*
(b) General nature of industry, business, or establishment in which employed (or employer), *Housewife*

9-BIRTHPLACE, (State or Country), *Baltimore Md.*
10-NAME OF FATHER, *Gauthier E. Akle*
11-BIRTHPLACE OF FATHER (State or Country), *Smithsburg, Md.*
12-MAIDEN NAME OF MOTHER, *Mary E. Looring*
13-BIRTHPLACE OF MOTHER (State or Country), *New York, N. Y.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant), *Henry M. Knirre*
(Address), *3420 Mondawmin Ave*

15-MAY 23 1915
Filed... 191... *3420 Mondawmin Ave* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 22*, 191*5*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *Jan 31* 191*5*, to *May 22* 191*5*, that I saw her alive on *May 21* 191*5*, and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs
(Duration) ... yrs. *6* mos. ds.

CONTRIBUTORY (Secondary) ...
(Signed) *Dr. C. O. ...* M. D.
May 23 191*5* (Address) *Arlington*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Greenmount Cemetery* DATE OF BURIAL, *May 24*, 191*5*

20-UNDERTAKER, *Henry W. ...* ADDRESS, *805 N. ...*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85529

C85529

CERTIFICATE OF DEATH.

10 REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1652 Gorsuch Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Nellie C. Finnegan(Residence in Baltimore: No. 1652 Gorsuch Ave St.: 48 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

43 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

at home

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Owen Finnegan

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary McKithick

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Katherine Finnegan(Address) 1652 Gorsuch Ave.

15-

Filed MAY 23 1915 HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

5-21 1915, to 5-22 1915,that I saw him alive on 5-22 1915,and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Heart Gripper(Duration) yrs. mos. ds. 3 ds.

CONTRIBUTORY (Secondary)

Cardiac dilatation(Duration) yrs. mos. ds. 1 ds.(Signed) A. G. Garrett M. D.5-23, 1915 (Address) 1631 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

May 24, 1915

20-UNDERTAKER

Wm W. Mead & Son

ADDRESS

805 N. Calver

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85530

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85530

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

311 N. Fulton Ave

St.:

19

WARD)

2-FULL NAME

Mary A. Hart

(Residence in Baltimore: No.

311 N. Fulton Ave

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

June

(Month)

(Day)

1848

(Year)

7-AGE,

66

yrs.

11

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER,

Richard Harding

11-BIRTHPLACE OF FATHER,

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Henrietta Talbot

13-BIRTHPLACE OF MOTHER,

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Alphens Hart

(Address).

311 N. Fulton Ave

15-

MAY 23 1915

HARRY O. ANDREWS

FILE

101

Serial Permit. Oler

Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH,

May

21 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

Inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

Inquiry

topsy or inquiry

on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Samt Winkler

May 23

1915

(Address)

2302 Madison Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death

yrs.

mos.

ds.

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Linden Park

DATE OF BURIAL,

May 24, 1915

20-UNDERTAKER

C. M. Mitehell & Co.

ADDRESS

1201 N. Fayette St.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85531

1. PLACE OF DEATH

CITY OF BALTIMORE (No. *1712 N. Gay*)

ST. *8* WARD)

2. FULL NAME

Mary E. Stevens

(Residence in Baltimore: No. *1712 N. Gay*)

St. *8* yrs. *9* mos. *9* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow*
(Write the word)

6. DATE OF BIRTH *Aug 13, 1840*
(Month) (Day) (Year)

7. AGE *74* yrs. *9* mos. *9* ds. or *less* than 1 day, *hrs.* or *min.?*

8. OCCUPATION
(a) Trade, profession, or particular kind of work *at Home*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country) *Balto Ind*

10. NAME OF FATHER *Jacob Steading*

11. BIRTHPLACE OF FATHER (State or country) *Germany*

12. MAIDEN NAME OF MOTHER *Mary Fisher*

13. BIRTHPLACE OF MOTHER (State or country) *Pennsylvania*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MAY 23 1915

Filed *1915*

HARRY O. ANDREWS

Marial Pot...

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 21, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 13, 1915*, to *May 21, 1915*, that I saw him *or* alive on *May 20th, 1915*, and that death occurred, on the date stated above, at *1302* m. The CAUSE OF DEATH* was as follows:

Senility

(Duration) *2* yrs. *10* mos. *10* ds.

Contributory (SECONDARY)

(Duration) *2* yrs. *10* mos. *10* ds.

(Signed) *J. D. Jones* M. D.

May 13, 1915 (Address) *1501 E. Bayview*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *1* yrs. *10* mos. *10* ds. In the State *1* yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85532

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 333 W Preston ST.; 11 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 333 W Preston St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Unknown, 1857 Jan 10 1913, to May 23 1915
(Month) (Day) (Year)

7-AGE,

58

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Waiter

Hotel

9-BIRTHPLACE, (State or Country),

Md

10-NAME OF FATHER,

John Paul

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

Bertha Russell
333 W Preston

15-

MAY 24 1915

ROBERT . KRAUTER,

Corial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 23 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 23 1915, to May 23 1915,

that I saw him alive on May 22 1915,

and that death occurred on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Organ Heart Disease
Bright's Disease
Abdominal (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) Samuel M. D.

May 23 1915 (Address) 437 Madison Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Samuel M. D. May 24 1915

20-UNDERTAKER

ADDRESS

Samuel M. D. 578 Madison

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85533

HEALTH DEPARTMENT—CITY OF BALTIMORE

182
C85533

CERTIFICATE OF DEATH.

PLACE OF DEATH

On gravel-walk, near the Cor. of
CITY OF BALTIMORE (No. Preston and Brevard sts. ST. 11 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Rosa Dobbins,

(Residence in Baltimore: No. 315 W. Preston st.

St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female,

4-COLOR OR RACE,

Colored,

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED,

(Write the word.)

Married,

6-DATE OF BIRTH,

Unknown,

(Month)

(Day)

(Year)

7-AGE,

24

yrs.

?

mos.

?

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House servant.

9-BIRTHPLACE,

(State or Country),

Washington, D. C.

PARENTS.

10-NAME OF FATHER,

George Thomas,

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland,

12-MAIDEN NAME OF MOTHER

Mary Ford,

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Ford, brother.

(Address) 315 W. Preston street.

15

MAY 24 1915.

ROBERT . KRAUTER,

Filed....., 191

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

20th

1915.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest.

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

Inquest

find that said deceased came to her death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal haemorrhage caused by a gunshot wound of the heart and lungs. (Homicide)

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. Frederick Humpal M. D.

(Coroner.)

May 21st 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs..... mos..... ds. In the State.... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn

May 27 1915

20-UNDERTAKER

ADDRESS

Sam'l Hunsley

578 W. Bond

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85535

CERTIFICATE OF DEATH.

151 C85535

1. PLACE OF DEATH

CITY OF BALTIMORE, (No. *Nursery & Childs Hosp* ST. *18* WARD)

2. FULL NAME

(Residence in Baltimore: No. *Nursery & Childs Hospital* St. yrs. *4* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

..... *1* *18* *1915*
(Month) (Day) (Year)

7-AGE,

..... yrs. *4* mos. *5* ds.

If LESS than 1 day,

.... hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), *unknown*10-NAME OF FATHER, *unknown*

11-BIRTHPLACE OF FATHER

(State or Country), *not known*12-MAIDEN NAME OF MOTHER *unknown*

13-BIRTHPLACE OF MOTHER

(State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frederick Mottner*(Address) *Nursery & Childs Hosp*

15-

MAY 24 1915

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 *23* *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

3/15/15 191 to *5/23/15* 191that I saw him alive on *5/23/15* 191and that death occurred, on the date stated above, at *6:30 P.*

The CAUSE OF DEATH* was as follows:

*Alimentary Decomposition**(Sero. Malnutrition)*(Duration)..... yrs. *2* mos. *2* ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *E. Egan* M. D.*May 24, 1915* (Address) *1616 Eastern Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *3* mos. *14* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

May 25, 1915

20-UNDERTAKER

George J. Smith

ADDRESS

5000 St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

085536

CERTIFICATE OF DEATH.

151 085536

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 576 Preston

ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John Turner

Residence in Baltimore: No. 576 Preston

St.: yrs. mos. da)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

Caucasian

5-SINGLE, Married, Widowed, or Divorced, (Write the word.) Infant

6-DATE OF BIRTH,

May 22, 1915
(Month) (Day) (Year)

7-AGE,

yrs. mos. da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Baltimore City

10-NAME OF FATHER,

John F. Turner

11-BIRTHPLACE OF FATHER (State or Country),

Charles Co. Md.

12-MAIDEN NAME OF MOTHER

Eva A. Cooper

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva A. Turner

(Address) 576 Preston St.

15-

MAY 24 1915

ROBERT KRAUTER,

Filed

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 22- 1915- to May 22- 1915-, that I saw him alive on May 22- 1915-, and that death occurred, on the date stated above, at 11:25 P.M. The CAUSE OF DEATH* was as follows:

Premature birth (7 mos.)
(Duration) 30 minutes
yrs. mos. da.

CONTRIBUTORY (Secondary)

(Signed) Chas. E. McPartland, M. D.
May 23, 1915 (Address) 906 Z. Street, N.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Undertaker
Blanche Beough

Address
314 Mary

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85537

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85537

PLACE OF DEATH

CITY OF BALTIMORE (No. 722 S. Bond

ST. 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta Louisa Brander

(Residence in Baltimore: No. 722 S. Bond

St.: 39 yrs. mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS

1-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH May 11, 1876 (Month) (Day) (Year)

7-AGE 39 yrs. mos. 11 ds. or min. 1 day, hrs. min. 7

8-OCCUPATION (a) Trade, profession, or particular kind of work Kept a Grocery Store (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Md.

10-NAME OF FATHER Henry Leonard Brander

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Wilhelmina Mickel

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lena Brander

(Address) 722 S. Bond St.

15 MAY 24 1915 ROBERT KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 22, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15, 1915, to May 22, 1915, that I saw her alive on May 21, 1915, and that death occurred, on the date stated above, at 8:25 A.M. The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(Duration) 7 yrs. mos. ds.

Contributory (SECONDARY) Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

(Signed) Henry H. Weinberger M. D. May 22, 1915 (Address) 724 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Evangelical Cemetery May 28, 1915

20-UNDERTAKER

He Lander Son 1710 Reed St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85538

CERTIFICATE OF DEATH.

3/C85538

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *Mercy Hospital* ST. *1* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

FULL NAME *Eva Hoffman*(Residence in Baltimore: No. *206 Patterson Park Ave.* St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. *Female* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widowed*
(Write the word.)

6-DATE OF BIRTH. *Jan. 3, 1862*
(Month) (Day) (Year)

7-AGE. *53 yrs. 4 mos. 19 ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). *Va.*

10-NAME OF FATHER. *Edw. Hay*

11-BIRTHPLACE OF FATHER (State or Country). *Va.*

12-MAIDEN NAME OF MOTHER. *Mattie Rice*

13-BIRTHPLACE OF MOTHER (State or Country). *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rebecca Mary Host*(Address) *Calvert St.*15- *LOBERT KRAUTER*MAY 24 1915 *Serial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *May 22, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 17, 1915*, to *May 22, 1915*, that I saw her alive on *May 22, 1915*, and that death occurred, on the date stated above, at *6:30 p.m.*

The CAUSE OF DEATH* was as follows:

Pericarditis
Coronary
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) *Edward J. Smith* M. D.
May 22, 1915 (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *5* In the *10* State *10* yrs. mos. ds.

Where was disease contracted if not at place of death? *206 Patterson Park Ave.*Former or usual residence *206 Patterson Park Ave.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Landon Park Cem. *May 24, 1915*

20-UNDERTAKER ADDRESS

M. Doyle & Son *156 Lee St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

102 C85539

PLACE OF DEATH

CITY OF BALTIMORE (No. *10 E. Centre St*)

REGISTERED NO. C

ST. *11* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

FULL NAME

Mary C. Phelan
108 E Centre St

(Residence in Baltimore: No. *108 E Centre St*)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word)

6 DATE OF BIRTH *July 15, 1857*
(Month) (Day) (Year)

7 AGE *57* yrs. mos. ds. or min. ? If LESS than 1 day, hrs.

8 OCCUPATION (a) Trade, profession, or particular kind of work *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Balto Md.*

PARENTS 10 NAME OF FATHER *Patrick Carey* 11 BIRTHPLACE OF FATHER (State or country) *Ireland* 12 MAIDEN NAME OF MOTHER *Mary Mahoney* 13 BIRTHPLACE OF MOTHER (State or country) *Ireland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs M. Pennead

(Address)

10 E Centre St

15 MAY 24 1915

ROBERT KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *5 22 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Feb 18*, 1915, to, *May 22* 1915, that I saw h. alive on *May 21*, 1915, and that death occurred, on the date stated above, at *6 A* m. The CAUSE OF DEATH* was as follows:

Ulcer of Stomach

Contributory (Duration) yrs. mos. ds. *3* *Hemorrhage of Stomach* (SECONDARY) (Duration) yrs. mos. ds. *1* (Signed) *G. M. Mahoney* M. D. *May 23, 1915* (Address) *1275 North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *New Cathedral*

DATE OF BURIAL *May 25, 1915*

20 UNDERTAKER *John J. Foley & Sons*

ADDRESS *1318 Light St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85540

CERTIFICATE OF DEATH

28
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 Otterbein St. 21 WARD)

2-FULL NAME

John Sands

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 515 Otterbein St.; yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE white 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH July 12 1887 (Month) (Day) (Year)

7-AGE 27 yrs. 10 mos. 10 ds. or min. If LESS than 1 day, hrs., min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Hatcher

9-BIRTHPLACE (State or country) Balt. Md.

10-NAME OF FATHER don't know

11-BIRTHPLACE OF FATHER (State or country) don't know

12-MAIDEN NAME OF MOTHER Lillie Worley

13-BIRTHPLACE OF MOTHER (State or country) Balt.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cora Sands

(Address) 515 Otterbein St.

15-

MAY 24 1915 ROBERT KRAUTER

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 22 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1913 to May 22 1915, that I saw him alive on May 21 1915, and that death occurred, on the date stated above, at 6 a. m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) about 19 yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) H. E. Kniff May 22 1915 [Address] 1602 N. Zennaro St. B.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Linden Park

DATE OF BURIAL

May 25 1915

20-UNDERTAKER

John Herman Sam

ADDRESS

901 Otterbein St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85541

HEALTH DEPARTMENT—CITY OF BALTIMORE

46
C85541

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Maryland General Hospital,
CITY OF BALTIMORE (No. Linden ave. & Madison st. ST. 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

James Brisco,

(Residence in Baltimore: No. Non-resident,

St. Three yrs, ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male,

4-COLOR OR RACE,

Colored,

5-SINGLE,

MARRIED Single,
WIDOWED
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH,

Unknown,

(Month)

(Day)

(Year)

7-AGE,

23

?

?

?

It LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Day laborer,

(b) General nature of industry, business, or establishment in which employed (or employer).

Farm work.

9-BIRTHPLACE.

(State or Country),

Maryland,

10-NAME OF FATHER,

Unknown,

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown,

12-MAIDEN NAME OF MOTHER

Unknown,

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) No informant,

(Address)

15-

MAY 24 1915

ROBERT J. KRAUTER,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

21st

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

inquiry and that said deceased came to his death

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Retropharyngeal growth, nature un-
known, pressing upon epiglottis
and larynx causing asphyxia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY

(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. Frederick Mumpel M. D.

(Coroner.)

May 22, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? X

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85542

CERTIFICATE OF DEATH.

91 C85542

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1501 William St* ST.; *24* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1501 William* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH

September 19th, 1870
(Month) (Day) (Year)

7-AGE

44 yrs. *8* mos. *2* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....*Police man*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Balto.*10-NAME OF FATHER, *Bernard Rehmman*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Antonie Born born*13-BIRTHPLACE OF MOTHER (State or Country), *Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mathias Rehmman*(Address) *1501 William St*

15-

Filed

MAY 24 1915

ROBERT

KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 21st, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 10 1915, to *May 21st 1915*,that I saw him alive on *May 21st 1915*,and that death occurred, on the date stated above, at *10:30* m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *J. J. O'Brien* M. D.*May 23rd 1915* (Address) *107 E. Wm*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Cross A. A. Co.

DATE OF BURIAL

May 26, 1915

ADDRESS

403 E. Wm

20-UNDERTAKER

Lilly & Zehn

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85543

CERTIFICATE OF DEATH.

152 C85543

PLACE OF DEATH

CITY OF BALTIMORE (No. 122 S. Wolfe St.)

ST.

WARD

2-FULL NAME

Franz Weidner

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 122 S. Wolfe St.)

St. yk.

mo.

da.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male	4-COLOR OR RACE, white	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)
6-DATE OF BIRTH, May 22 nd , 1915 (Month) (Day) (Year)		
7-AGE, If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).		

9-BIRTHPLACE,
(State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER, Frank Weidner	11-BIRTHPLACE OF FATHER (State or Country), Baltimore
12-MAIDEN NAME OF MOTHER, Rhea Simpson	13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Franz Weidner

(Address) 122 S. Wolfe St.

15 MAY 24 1915, ROBERT KRAUTH,
Filed, 191. Burial Permit Given

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 22nd, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Obstructive pneumonia
8 months in duration
(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.
(Signed) David W. Jones, M. D.
(Coroner.)
May 22, 1915. (Address) 1116 Gilman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hoy Melanor

May 24, 1915.

20-UNDERTAKER

ADDRESS

Luby & Zuber

403 S. Wolfe St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *5* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Martin M. Mearns*(Residence in Baltimore: No. *St James Home for Boys* St. *Low & High St.* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word.) *Single*6-DATE OF BIRTH, *Not known*

(Month)

(Day)

(Year)

7-AGE, *18*yrs. *1* mos. *1* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *School Boy*(b) General nature of industry, business, or establishment in which employed (or employer) *✓*9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *Not known*11-BIRTHPLACE OF FATHER (State or Country), *Not known*12-MAIDEN NAME OF MOTHER *Not known*13-BIRTHPLACE OF MOTHER (State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Record Mearns, Jr.*(Address) *Calvert St.*

15-

MAY 24 1915

ROBERT K. KRAUTER

Burial Permit Officer

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 24, 1915*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *May 18, 1915* to *May 24, 1915*that I saw him alive on *May 24, 1915*and that death occurred, on the date stated above, at *12:30 A.M.*

The CAUSE OF DEATH* was as follows:

Acute Paratyphoid
Dysentery
(Duration) *Don't know* yrs. *1* mos. *1* ds.CONTRIBUTORY *Unknown*

(Secondary)

(Duration) *7* yrs. *1* mos. *1* ds.(Signed) *Edward Smith* M. D.*May 24, 1915* (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *6* yrs. *1* mos. *1* ds. In the State *Life* yrs. *1* mos. *1* ds.Where was disease contracted, if not at place of death? *St James Home*Former or usual residence *St James Home*19-PLACE OF BURIAL OR REMOVAL, *Cathedral Ave*DATE OF BURIAL, *3/23/15*20-UNDERTAKER, *Chas. P. Evans Son*ADDRESS, *West Royal Ave*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85545

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 C85545
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *614 N. Hoffman* ST.; *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *614 N. Hoffman* St. *34* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Unknown, *1864*
(Month) (Day) (Year)

7-AGE,

54

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housework*

9-BIRTHPLACE, (State or Country),

MD

10-NAME OF FATHER,

Joshua Green

11-BIRTHPLACE OF FATHER (State or Country),

MD

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-MAY 24 1915

ROBERT KRAUTER

Filed

191

Burial

Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May *21*, *1915*
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from

Mar. 10 191*5*, to *May 21* 191*5*that I saw her alive on *May 21* 191*5*and that death occurred, on the date stated above, at *5 P* m.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) *4* yrs. *—* mos. *—* ds.CONTRIBUTORY (Secondary) *Pulmonary*(Signed) *W. E. Canby* M. D.*May 24*, 191*5*. (Address) *515 Thayer*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel Home *5/24/15*ADDRESS *Laurel Home*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 C85546
REGISTERED NO. C

1 PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *7* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Dorothy Varrina*
(Residence in Baltimore: No. *522 Curley St.* St.; *2* yrs. *8* mos. *8* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
6-DATE OF BIRTH *September 6, 1912*
(Month) (Day) (Year)
7-AGE *2* yrs. *8* mos. *8* ds. or min.?
If LESS than 1 day, hrs.
8-OCCUPATION *None*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE *ind.*
(State or country)

PARENTS

10-NAME OF FATHER *Chas. Varrina*
11-BIRTHPLACE OF FATHER *Ill.*
(State or country)
12-MAIDEN NAME OF MOTHER *Mary Stasny*
13-BIRTHPLACE OF MOTHER *Bohemia*
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 MAY 24 1915

ROBERT . KRAUTH

Filed

191

Bureau of Health
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 22, 1915*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *May 17, 1915*, to *May 22, 1915*, that I saw her alive on *May 22, 1915*, and that death occurred, on the date stated above, at *10:40 p.m.*

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Contributory
(SECONDARY)

(Duration) yrs. *6* mos. *8* ds.
(Signed) *Alvin S. Rothholz* M. D.
May 22, 1915 [Address] *Johns Hopkins Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. *5* In the State yrs. *5* mos. *8* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *522 Curley St.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Hill

May 24, 1915

20-UNDERTAKER

ADDRESS

Frank Swachnow 909 Cylford

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 South Sharp ST.; 23 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 830 South Sharp St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,WIDOWED,OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH,

Unknown, 1861.
(Month) (Day) (Year)

7-AGE,

54

IF LESS than 1 day,

.... hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Porter9-BIRTHPLACE,
(State or Country),Accomac Co. Md.

10-NAME OF FATHER,

Unknown11-BIRTHPLACE OF FATHER
(State or Country),Unknown

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet Bailey(Address) 830 S. Sharp St.

15-

Filed

MAY 24 1915ROBERT KRAUTHBurial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 22, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 22 1915, to May 22 1915,that I saw him alive on May 2 1915,and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Arterial)

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... Charles H. Follen..... M. D.May 22 1915. (Address) 712 S. Sharp St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Auburn Cem.5/24, 1915.

20-UNDERTAKER

ADDRESS

John H. Toadwin142 W. Walters

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85548

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 C85548

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and full out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word)

6-DATE OF BIRTH *June 9, 1893*
(Month) (Day) (Year)

7-AGE *21* yrs. *11* mos. *13* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
Housewife

9-BIRTHPLACE (State or country)
Baltimore

10-NAME OF FATHER
Geo. Wright

11-BIRTHPLACE OF FATHER (State or country)
Virginia

12-MAIDEN NAME OF MOTHER
Catherine Hawkins

13-BIRTHPLACE OF MOTHER (State or country)
Mainland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Wm Wright*

(Address) *417 W. Hamburg St*

15-MAY 24 1915 ROBERT . KRAUTER, Registrar

Filed *gocw* 1915

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 22, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY That I attended deceased from *April 1, 1915* to *May 22, 1915* that I saw him alive on *May 21, 1915* and that death occurred, on the date stated above, at *6:18 pm*. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) yrs. *5* mos. ds.

Contributory (SECONDARY) *None*
(Duration) yrs. mos. ds.

(Signed) *W.C. Greulicher, M.D.*
May 22, 1915 (Address) *680 Columbia Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Int. Auburn Cem* DATE OF BURIAL *May 25, 1915*

20-UNDERTAKER *John H. Toadmi* ADDRESS *14 W. Hill St*

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85549 HEALTH DEPARTMENT—CITY OF BALTIMORE

151
C85549

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1120 Whatcoat street, St. 16 WARD)

FULL NAME Infant of Agnes Chase,

(Residence in Baltimore: No. 1120 Whatcoat street, St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, May 21st, 1915, (Month) (Day) (Year)

7-AGE, 0 yrs., 0 mos., 5 hrs., If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS. 10-NAME OF FATHER, Charles Sales, 11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md., 12-MAIDEN NAME OF MOTHER, Agnes Chase, 13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Chase, mother,

(Address) 1120 Whatcoat street?

15- MAY 24 1915, ROBERT KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, May 21st, 1915, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature birth (8 months Utero-gestation)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frederick H. Campbell, M. D. (Coroner.)

May 22, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt. Zion, May 24, 1915

20-UNDERTAKER, ADDRESS

James H. Dennis, 1303 Lexington

C85550

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 C85550

REGISTERED NO. CC 85550

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2342 Montebello St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mamie Devine Johnson*

(Residence in Baltimore: No. 2342 Montebello Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Unknown*, 1901 (Month) (Day) (Year)7-AGE, *14* yrs. *14* mos. *14* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work *at home*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Horace Devine*11-BIRTHPLACE OF FATHER (State or Country), *VA*12-MAIDEN NAME OF MOTHER *Harriet Winston*13-BIRTHPLACE OF MOTHER (State or Country), *VA*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harriet Devine*(Address) *2342 Montebello Ave.*

15- MAY 24 1915 ROBERT KRAUTH

Filed *Yes* 1915 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May (21)* 21, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 11* 1915, to *May 21* 1915, that I saw him alive on *May 20* 1915, and that death occurred, on the date stated above, at *7 P* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis
inman (Duration) yrs. mos. ds.CONTRIBUTORY *Lotemia* (Secondary)*10 days* (Duration) yrs. mos. ds. (Signed) *J. Edward M. D.**May 12 1915* (Address) *1. 2. 3. 4. 5. 6. 7. 8. 9. 10.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, *Laurel Cemetery* DATE OF BURIAL, *May 25 1915*20-UNDERTAKER *Robert E. Elliott* ADDRESS *506 Bayview Ave.*

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85552

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85552

CERTIFICATE OF DEATH.

PLACE OF DEATH
 CITY OF BALTIMORE (NO. *Found off Pier # 5 Pratt St.* ST. *4* WARD)
 FULL NAME *Edward Rosenrochel*
 (Residence in Baltimore: No. *206 N. Gay St.* St.; yrs. mos. ds.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*
 4-COLOR OR RACE, *White*
 5-SINGLE, MARRIED, WIDOWED, OR-DIVORCED, *Single*
 (Write the word.)
 6-DATE OF BIRTH, *Not Known*, 1
 (Month) (Day) (Year)
 7-AGE, *25* yrs. mos. ds. If LESS than 1 day, hrs. or min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Galvener*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), *Germany*
 10-NAME OF FATHER, *Not Known*
 11-BIRTHPLACE OF FATHER (State or Country), *Not Known*
 12-MAIDEN NAME OF MOTHER, *Not Known*
 13-BIRTHPLACE OF MOTHER (State or Country), *Not Known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *S. Giverson + Bros.*
 (Address) *1107 E. Baltimore St.*

15-MAY 24 1915 ROBERT KRAUTER,
 Filed..... 191. *Bureau Permit Clerk*
 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Found May 20*, 1915.
 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:
Provençal - low cause of unknown
No signs of injury
 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
 (Signed) *Thos. H. Chamber* M. D.
May 24 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
 At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.
 Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Hebrew Bur.* DATE OF BURIAL, *May 25 1915*

20-UNDERTAKER *S. Giverson + Bros.* ADDRESS *1107 E. Baltimore St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85553

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85553

CERTIFICATE OF DEATH.

156

PLACE OF DEATH

CITY OF BALTIMORE (No. *2681 Wilkens Ave* ST. *20* WARD)

FULL NAME *Frank E. Schadel*

(Residence in Baltimore: No. *2681 Wilkens Ave*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

June 10th, 1873.
(Month) (Day) (Year)

7-AGE,

41 yrs., 11 mos., 11 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Balto. Md.

10-NAME OF FATHER,

Jacob Schadel

11-BIRTHPLACE OF FATHER (State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Pauline Rupp

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elizabeth Schadel*

(Address) *2681 Wilkens Ave*

15-

MAY 24 1915

ROBERT KRAUTER

Chief Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 21st, 1915.
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*, au-

Inquest find that said deceased came to *his* death
topsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastrophygia Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Samt Winterberg* M. D.

May 23rd, 1915. (Address) *202 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery

May 24, 1915.

20-UNDERTAKER

ADDRESS

Edw. J. Fanning - 1938 E. Lafayette Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. **1032 N. Stricker st.** ST. **16** WARD)

FULL NAME **George R. Finch,**

(Residence in Baltimore: No. **1032 N. Stricker st.** St.; yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. **Male,** 4-COLOR OR RACE, **White,** 5-SINGLE, **Married,** (Write the word.)

6-DATE OF BIRTH, **January 3d, 1855.** (Month) (Day) (Year)

7-AGE, **60 yrs., 4 mos., 19 ds.** If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, **Traveling** (b) General nature of industry, business, or establishment in which employed (or employer), **hardware sales-**

9-BIRTHPLACE, (State or Country), **man,**

Virginia, 10-NAME OF FATHER, **George R. Finch,**

11-BIRTHPLACE OF FATHER (State or Country), **Virginia,**

12-MAIDEN NAME OF MOTHER **Ann Hart,**

13-BIRTHPLACE OF MOTHER (State or Country), **Virginia,**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Martha W. Finch, wife,**

(Address) **1032 N. Stricker street.**

15- **MAY 24 1915** **ROBERT KRAUTER** **Burial Permit Clerk**

Filed, 191. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, **May 22nd, 1915.** (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an **inquiry** (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said **inquiry** and that said deceased came to his death (Inquest, au- topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular heart disease.

(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary)

(Duration)yrs.mos.ds.

(Signed) **J. Frederick Heindel** M. D. (Coroner.)

May 22, 1915 (Address) **3310 W. North ave.**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park **May 24 1915**

20-UNDERTAKER

ADDRESS

W. J. Lickner **North Pe**

C 85556

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 C 85556

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612. Gough.

ST.: 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME

Maciej Palczynski

(Residence in Baltimore: No. 1612. Gough St.

St.: 27 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX.

Male

4. COLOR OR RACE.

White

5. SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

6. DATE OF BIRTH,

Nov.

Know.

1861

(Month)

(Day)

(Year)

7. AGE,

54

If LESS than 1 day,

....hrs. or....min.?

8. OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer).

Farm.

9. BIRTHPLACE,

(State or Country),

Germany.

PARENTS.

10. NAME OF FATHER,

Peter Palczynski

11. BIRTHPLACE OF FATHER

(State or Country),

Germany.

12. MAIDEN NAME OF MOTHER

Wilhelmina Zmich

13. BIRTHPLACE OF MOTHER

(State or Country),

Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Anne Palczynski

(Address)

1612. Gough St.

15.

MAY 24 1915

ROBERT KRAUTER,

Filed

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH,

May

22

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1, 1915, to May 22, 1915,

that I saw him alive on May 22, 1915,

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed)

May 24, 1915. (Address) 115 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary

May 25, 1915

UNDERTAKER

ADDRESS

William T. Galloway

1618 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

085557

CERTIFICATE OF DEATH

50 085557
REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1934 Hanover St. 23 WARD)

2-FULL NAME

Friedrich G Walper

(Residence in Baltimore: No. 1934 Hanover St. 7 yrs. 2 mos. 13 ds.)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

August 3, 1907, 1

7-AGE

7 yrs. 9 mos. 16 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Baltimore Md.

10-NAME OF FATHER

Friedrich G Walper

11-BIRTHPLACE OF FATHER (State or country)

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Katie Walper

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Friedrich G Walper

(Address)

1934 Hanover St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 22, 1915

17- I HEREBY CERTIFY, That I attended deceased from

May 20, 1915, to May 22, 1915

that I saw him alive on

May 22, 1915

and that death occurred, on the date stated above, at 11 a m

The CAUSE OF DEATH* was as follows:

Acute malarial infection
Diabetes

Contributory (SECONDARY)

Diabetic coma

(Signed),

Harry G. M. Jones
May 24, 1915 (Address) 1508 N. Capitol

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Cemetery

DATE OF BURIAL

May 25, 1915

20-UNDERTAKER

Mrs. J. E. Evans
Sons

ADDRESS

1428 Schaub
St.

15 MAY 24 1915

ROBERT K. KRAUTER,

Marial Permit Clerk

REGISTRAR

C8555

HEALTH DEPARTMENT—CITY OF BALTIMORE

C8555

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Patapsco River off Fort Small St.*)

FULL NAME

Carl Hamman

(Residence in Baltimore: No. *County*)

3911 Mt Pleasant Ave

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Aug 21 - 1884
(Month) (Day) (Year)

7-AGE,

70 yrs. 9 mos. 2 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Albertine*

(Address) *3911 Mount Pleasant Ave*

15-

Filed *MAY 24 1915* *HARRY O. ANDREWS*
Marial Peralt Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 23rd, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*

(Inquest, au-

inquest and that said deceased came to *his* death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *D. W. Jones* M. D.
(Coroner.)

May 23, 1915 (Address) *3116 Chesebrough St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? *X*

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Immanuel Cemetery May 26 1915

20-UNDERTAKER

ADDRESS,

Louis Heenan 72 S Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *403 W. 40th St.* ST. *13th* WARD)

2-FULL NAME *Willie Day Myler*

(Residence in Baltimore: No. *903 W. 40th St.* St. *18* yrs. *18* mos. *18* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*

4-COLOR OR RACE *white*

5-SINGLE *Single*

~~MARRIED~~

~~WIDOWED~~

~~OR DIVORCED~~

(Write the word)

6-DATE OF BIRTH *February 24, 1897*

(Month)

(Day)

(Year)

7-AGE *18* yrs. *2* mos. *23* ds. or min.?

If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work *Trusts worker in*

(b) General nature of industry, business, or establishment in which employed (or employer) *Cotton mill*

9-BIRTHPLACE (State or country) *Balts. City Md.*

10-NAME OF FATHER *William H. Myler*

11-BIRTHPLACE OF FATHER (State or country) *Balts. Co. Md.*

12-MAIDEN NAME OF MOTHER *Mary Weir*

13-BIRTHPLACE OF MOTHER (State or country) *Balts. Co. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Wm H. Myler*

(Address) *903 W. 40th St.*

MEDICAL CERTIFICATE OF DEATH

15-DATE OF DEATH *May 23rd, 1915*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *Jan 1st, 1915* to *May 18th, 1915*

that I saw her alive on *May 22nd, 1915* and that death occurred, on the date stated above, at *8:30 p.m.*

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency, Mitral stenosis with regurgitation

Contributory (SECONDARY)

(Duration) *8* yrs. *6* mos. *8* ds.
Acute nephritis (chronic)
(Signed) *Vernon J. Kelly*
5/24, 1915 [Address] *3705 Jackson Ave.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *18* yrs. *18* mos. *18* ds. State *18* yrs. *18* mos. *18* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL *May 26th, 1915*

20-UNDERTAKER *Wm H. Myler*

ADDRESS *3705 Jackson Ave.*

15-MAY 24 1915

HARRY O. ANDREWS,
Burial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *13* ST.; *13* WARD)2-FULL NAME *Charles Brown*(Residence in Baltimore: No. *813 W. 35th St.* St.; *—* yrs.; *—* mos.; *—* ds.)REGISTERED No. C *646 85500*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, *Married*

(Write the word.)

6-DATE OF BIRTH, *May 14, 1840*

(Month)

(Day)

(Year)

7-AGE, *75* yrs. *0* mos. *8* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *None*9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *Not known*11-BIRTHPLACE OF FATHER (State or Country), *Not known*12-MAIDEN NAME OF MOTHER *Not known*13-BIRTHPLACE OF MOTHER (State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. H. Brown*(Address) *813 W. 35th St.*15 *MAY 24 1915*

HARRY O. ANDREWS,

Filed.....

191..

Bar. 1st

Permit 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 22, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 14 1915*, to *May 22 1915*,that I saw him alive on *May 22 1915*,and that death occurred, on the date stated above, at *9:00* m.

The CAUSE OF DEATH* was as follows:

*General Arterio-Sclerosis**Don't know*CONTRIBUTORY (Secondary) *Cerebral Hemorrhage*(Duration) *Don't know*(Signed) *Edward J. Smith* M. D.*May 22 1915* (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *9* yrs. *0* mos. *8* ds. In the *Life* State *Life* yrs. *0* mos. *8* ds.Where was disease contracted, if not at place of death? *813 W. 35th St.*Former or usual residence *813 W. 35th St.*19-PLACE OF BURIAL OR REMOVAL, *Maryland Hospital*20-UNDERTAKER *Chenoweth & Son*DATE OF BURIAL, *May 25, 1915*ADDRESS *Chestnut*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85561

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

119 C85561

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *824 George* St. *17* WARD)

2-FULL NAME *Francis J. Thomas*

(Residence in Baltimore: No. *824 George* St. *17* yrs. — mos. — ds.)

REGISTERED NO. C

(if death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED *Married*

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

Unknown 1843

(Month)

(Day)

(Year)

7-AGE

72 yrs. — mos. — ds. or min.?

IF LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

Barber

9-BIRTHPLACE

(State or country)

Baltimore Md.

10-NAME OF FATHER

Wm. J. Thomas

11-BIRTHPLACE OF FATHER

(State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Mary Labar

13-BIRTHPLACE OF MOTHER

(State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. W. Hughes*

(Address) *824 George St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

24

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 16th, 1915, to, *May 24th*, 1915,

that I saw him alive on *May 23^d*, 1915,

and that death occurred, on the date stated above, at *1:30 p.m.*

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

Neuritis of the heart

(Signed) *Edmund A. Mackenzie*

May 24th, 1915. (Address) *1327 N. Market St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cathedral Cemetery

DATE OF BURIAL

May 26th, 1915

20-UNDERTAKER

Felix B. Page

ADDRESS

112 E. Mulberry St.

MAY 24 1915

Filed

191

HARRY O. ANDREWS,

Burial Permit Clerk.

REGISTRAR

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C35562

HEALTH DEPARTMENT—CITY OF BALTIMORE

20

C35562

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital,
CITY OF BALTIMORE (No. Linden ave. & Madison st. ST. 14 WARD)
2-FULL NAME Jacob A. Hill,
(Residence in Baltimore: No. 1911 N. Brunt st.

REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed,
6-DATE OF BIRTH, June 2, 1915 (Month) (Day) (Year)
7-AGE, 51 yrs. 2 mos. 2 ds. If LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Stevedore, (b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), Virginia,
10-NAME OF FATHER, Turner Hill,
11-BIRTHPLACE OF FATHER (State or Country), Virginia,
12-MAIDEN NAME OF MOTHER, Caroline Edwards,
13-BIRTHPLACE OF MOTHER (State or Country), Virginia,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George H. Hines, nephew,
(Address) 1911 N. Brunt street.

15- MAY 24 1915
Filed 1915 HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21st, 1915 (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) And that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Systemic septicaemia caused by an accidental infection of the large toe of right foot.
(Duration) yrs. mos. ds.
CONTRIBUTORY Septic pneumonia, (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. H. Hines, M. D. (Coroner.)
May 22, 1915 (Address) 3310 W. North ave.,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, J. H. Hines, Va. DATE OF BURIAL, May 22, 1915
20-UNDERTAKER, Felix B. Pye ADDRESS, 102 E. Mulberry St.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

85563

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64

85563

PLACE OF DEATH

CITY OF BALTIMORE (No. 418 St Mary St)

FULL NAME

(Residence in Baltimore: No. 418 St Mary St)

REGISTERED NO. C

St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME. Instead of street and number and fill out No. 11.)

St. 65 yrs. 7 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day,hrs.
ormin.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF
FATHER

11 BIRTHPLACE
OF FATHER
(State or country)

12 MAIDEN NAME
OF MOTHER

13 BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 MAY 24 1915

HARRY O. ANDREWS,

Filed

191

Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 23

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 14, 1915, to, May 22, 1915.

that I saw her alive on May 22, 1915.

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH was as follows:

apoplexy

(Duration)

yrs.

mos.

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

J. G. Hiltner, M. D.

May 23, 1915

(Address) 512 N. 4th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

May 26, 1915

20-UNDERTAKER

ADDRESS

Felix B. Pfeiffer

12 E. Mulberry St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C35564

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28

C35564

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

2605 Pennsylvania Ave

ST.

13

WARD)

2-FULL NAME

John E Heaton

(Residence in Baltimore: No.

2605 Pennsylvania Ave

St.;

45 yrs. 1 mos. 9 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

6-DATE OF BIRTH

April

12

1870

(Month)

(Day)

(Year)

7-AGE

45

yrs.

1

mos.

9

ds.

IF LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

Iron worker

9-BIRTHPLACE

(State or country)

Baltimore City

10-NAME OF FATHER

Vincent Heaton

11-BIRTHPLACE OF FATHER

(State or country)

MD

12-MAIDEN NAME OF MOTHER

Mary Clark

13-BIRTHPLACE OF MOTHER

(State or country)

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Meagher

(Address)

2605 Penna Ave

15

MAY 24 1915

HARRY O. ANDREWS,

Marial Permit Clerk

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

21

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 10

1915

to

May 21

1915

that I saw him alive on

May 21

1915

and that death occurred, on the date stated above, at 5720

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs and glands

(Duration)

1

yrs.

6

mos.

ds.

Contributory (SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

Fred O Jewett

M. D.

May 24, 1915

(Address)

2635 Penn. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

Where was disease contracted, if not at place of death?

Former or

usual residence

In the

State

yrs.

mos.

ds.

19-PLACE OF BURIAL OR REMOVAL

Cathedral

DATE OF BURIAL

May 28, 1915

20-UNDERTAKER

Martin Fabeys, 406 Lafayette

ADDRESS

C85565

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85565

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1606 Barnes* ST. *7* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1606 Barnes* St. — yrs., — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH

August 24th, 1855
(Month) (Day) (Year)

7-AGE,

59 yrs. 9 mos. — ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Storekeeper*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Bohemia

10-NAME OF FATHER,

Albert Lhotsky

11-BIRTHPLACE OF FATHER (State or Country),

Bohemia

12-MAIDEN NAME OF MOTHER

Marie Preska

12-BIRTHPLACE OF MOTHER (State or Country),

Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Marie Lhotsky*(Address) *1606 Barnes St.*

15-

MAY 24 1915 HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 22nd, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Jan 15, 1915* to *May 22, 1915*, that I saw him alive on *May 22, 1915*, and that death occurred, on the date stated above, at *2:25* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) *4* yrs. *14* mos. *—* ds.

CONTRIBUTORY (Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.(Signed) *William J. Keenan, M.D.*
May 24, 1915 (Address) *2001 Park Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

May 25, 1915

20-UNDERTAKER

Geo M. Fink

ADDRESS

811 N. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85566

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *543 W. Linnale* ST.: *17* WARD)

REGISTERED NO. C

3-FULL NAME

(Residence in Baltimore: No. *543 W. Linnale* St.: *6* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *child*

6-DATE OF BIRTH,

(Month) *Feb* (Day) *18* (Year) *1909*

7-AGE,

6 yrs., mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *School Boy*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Balt Md

10-NAME OF FATHER,

Henry Davis

11-BIRTHPLACE OF FATHER (State or Country),

annapolis Md

12-MAIDEN NAME OF MOTHER

Katherine Green

13-BIRTHPLACE OF MOTHER (State or Country),

Leesburg Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Davis*(Address) *5-43 W. Linnale*

15-

Filed

*MAY 25 1915**ROBERT J. KRAUTER**Burial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 22, 1915
(Month) (Day) (Year)I HEREBY CERTIFY That I attended deceased from *May 10 1915* to *May 22 1915*that I saw him alive on *May 22 1915* and that death occurred, on the date stated above, at *12:10* m.

The CAUSE OF DEATH* was as follows:

Influenza Meningitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Dr. J. Carr* M. D.*May 22 1915* (Address) *575 N. Hollister St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Auburn

DATE OF BURIAL,

May 26, 1915

20-UNDERTAKER

John H. Owens

ADDRESS

1222 Avenue

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85567

CERTIFICATE OF DEATH.

176

C85567

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 S. Luzerne

ST.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Catherine Seifert

(Residence in Baltimore: No. 700 S. Luzerne

St.; 50 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED, Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 20, 1852
(Month) (Day) (Year)

7-AGE,

62 yrs., 11 mos., 27 ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

Peter Neu

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Catherine Schmidt

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

August Seifert

(Address)

700 S. Luzerne St.

15-

MAY 25 1915

ROBERT . KRAUTER,

Filed

Marital Permit Officer
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 23, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 1, 1913, to May 23, 1915, that I saw him alive on May 23, 1915, and that death occurred, on the date stated above, at 4:00 p. m.
The CAUSE OF DEATH* was as follows:Chronic Infectious Mononucleosis
(Duration) 1 yrs., 10 mos., ds.CONTRIBUTORY
(Secondary)(Signed) J. M. J. Insley, M. D.
(Address) 7585 E. 4th St.,
1915.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Carmel

DATE OF BURIAL,

May 26, 1915

20-UNDERTAKER

Gunkler & Gunkler

ADDRESS

1739 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

085568

CERTIFICATE OF DEATH.

170085568

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1439 E Eager ST.; 10 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1439 E Eager St.; unknown yrs., unknown mos., unknown ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word.)

6-DATE OF BIRTH May 1829
(Month) (Day) (Year)

7-AGE 86 yrs. 3 mos. 3 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country), Germany

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Rollman

(Address) 1439 E Eager St.

15- MAY 25 1915. ROBERT J. KRAUTER, Registrar.

Filed 1915 Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH May 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 15 1915 to May 22 1915, that I saw her alive on May 22 1915, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 6 yrs. 6 mos. 6 ds.

CONTRIBUTORY Endocarditis
(Secondary)

(Duration) 4 yrs. 4 mos. 4 ds.

(Signed) John T. Arvey M. D.

May 24, 1915. (Address) 1603 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. 6 mos. 6 ds. In the 6 yrs. 6 mos. 6 ds. State 6 yrs. 6 mos. 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL.

Baltimore Cemetery May 25, 1915.

20-UNDERTAKER ADDRESS

Robt T. Turner 1442 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

085569

085569

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *1610 N Register* ST. *8* WARD)

2-FULL NAME *Eva M Westerhoff*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

(Residence in Baltimore: No. *1610 N Register* St.; *unknown* yrs. *unknown* mos. *unknown* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *September 8, 1862*
(Month) (Day) (Year)

7-AGE *52* yrs. *8* mos. *16* ds. or *16* min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Germany*

10-NAME OF FATHER *Don't know*

11-BIRTHPLACE OF FATHER (State or country) *Germany*

12-MAIDEN NAME OF MOTHER *Don't know*

13-BIRTHPLACE OF MOTHER (State or country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *August Westerhoff*

(Address) *1610 N. Register St.*

15- MAY 25 1915 ROBERT KRAUTER
MAY 25 1915

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 23, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Nov 29, 1914*, to, *May 23, 1915*, that I saw *her* alive on *May 23, 1915*, and that death occurred, on the date stated above, at *5:10 p.m.*

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Contributory (SECONDARY)

(Signed) *John W. Sanderson* M. D.
May 24, 1915 [Address] *1714 N. Broadway*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *17* yrs. *0* mos. *0* ds. In the State *17* yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Holy Redeemer Cent. *May 26, 1915*

20-UNDERTAKER ADDRESS

W. J. Turner *1442 N. Broadway*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085570

HEALTH DEPARTMENT—CITY OF BALTIMORE

085570

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 516 Hubbard Alley

ST.:

WARD)

REGISTERED NO. C

FULL NAME

Luther A Stevens

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 516 Hubbard Alley

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 11, 1881 (Month) (Day) (Year)

7-AGE, 33 yrs. 10 mos. 12 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md

10-NAME OF FATHER, Geo W Stevens

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Henrietta Gibson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Stevens

(Address) 516 Hubbard Alley

15- MAY 25 1915 ROBERT KRAUTER, Registrar.

Filed, 1915

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 23, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.

I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural causes probably Organic heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Elyah P. Casper, M. D. (Coroner.)

May 23, 1915 (Address) 423 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place in the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Asbury Cem

DATE OF BURIAL, May 25 1915

20-UNDERTAKER, Harry A. Voderay

ADDRESS, 1725 Orleans St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85571

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 C85571

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 20 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH April 18, 1873 (Month) (Day) (Year)

7-AGE 72 yrs. 1 mos. — ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE (State or country) Maryland

10-NAME OF FATHER Jesse Holliday

11-BIRTHPLACE OF FATHER (State or country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Margaret Davis

13-BIRTHPLACE OF MOTHER (State or country) Annapolis Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

MAY 25 1915

ROBERT KRAUTER

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 24, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY. That I attended deceased from March 15, 1915 to May 25, 1915. that I saw her alive on May 25, 1915. and that death occurred, on the date stated above, at 7 A. m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Contributory (SECONDARY)

Central Adenoma (Duration) yrs. 3 mos. ds. Signed, William Francis M. D. (Address) 1407 N. Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Louisa Park

DATE OF BURIAL

May 26, 1915

20-UNDERTAKER

Geo. W. W. W.

ADDRESS

1442 N. Gay

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

085572

170 085572

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

2108 Clifton Ave

ST.

15

WARD)

2-FULL NAME

Catherine Blumberger

(Residence in Baltimore: No.

2108 Clifton Ave

St. 55 yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH Jan 15, 1845 (Month) (Day) (Year)

7-AGE 70 yrs. 4 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work at home (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Germany

10-NAME OF FATHER 2. Gael

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Whorltable

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles J. Frank

(Address) 2108 Clifton Ave

15. MAY 25 1915 ROBERT J. KRAUTER, Burial Permit Clerk REGISTRAR

16-DATE OF DEATH May 23, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1915, to May 23, 1915, that I saw her alive on May 23, 1915, and that death occurred, on the date stated above, at 4:20 p.m. The CAUSE OF DEATH* was as follows: Interstitial nephritis

(Duration) 1 yrs. 1 mos. 5 ds. Contributory (SECONDARY) Exhaustion

(Signed) W. J. Kestner M. D. May 25, 1915 (Address) W. J. Kestner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Western Cemetery DATE OF BURIAL May 25, 1915

20-UNDERTAKER William Cook ADDRESS 502 E North Ave

085573

HEALTH DEPARTMENT—CITY OF BALTIMORE

170 085573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 N. Caroline ST.; 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1515 N. Caroline st St.; 50 yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 10th, 1878
(Month) (Day) (Year)

7-AGE, 67 yrs., 1 mos., 14 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Grocer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

10-NAME OF FATHER, John Snyder

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louisa Falkenstein

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Justina Snyder.....

(Address).....1515 N. Caroline st.....

15- MAY 25 1915 ROBERT . KRAUTER,
Filed.....1915.....1515 N. Caroline st
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 24, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1912, to May 23 1915, that I saw him alive on May 23 1915, and that death occurred, on the date stated above, at 2 A. m. The CAUSE OF DEATH* was as follows:

Uremia
(Duration) X yrs., X mos., 1 ds.
CONTRIBUTORY (Secondary) Chr. Paralysis motus
(Duration) 15 yrs., 10 mos., 1 ds.
(Signed).....1507 Duke M. D.
May 24, 1915. (Address).....928 E. North A.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

May 26, 1915.

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85574

CERTIFICATE OF DEATH

40. C85574

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C.....

CITY OF BALTIMORE: (No.

East Monument St.

ST.

WARD)

2-FULL NAME

Henry Gernhardt

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM at No. 18.)

(Residence in Baltimore: No.

818 North Montford Ave

St. 42 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OF RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

Oct 12th 1872
(Month) (Day) (Year)

7-AGE

42 yrs. 7 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Police

9-BIRTHPLACE
(State or country)

Md

10-NAME OF FATHER

Jacob Gernhardt

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Marie

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jennie Gernhardt
(Address) 818 N. Montford Ave

15-

MAY 25 1915 ROBERT J. KRAUTH, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 20, 1915, to, May 23, 1915,

that I saw him alive on May 23, 1915,

and that death occurred, on the date stated above, at 5:50 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(Operation + Microscopic Examination)

(Duration) yrs 3 mos. ds.

Contributory
(SECONDARY)

Post operative shock

(Duration) yrs 1 mos. ds.

(Signed),

M. B. Kevin

M. D.

May 23, 1915, [Address] Hebrew Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs 4 mos. 42 ds. State 42 yrs. mos. ds.

Where was disease contracted, 818 N. Montford Ave
If not at place of death?

Former or usual residence 818 N. Montford Ave

19-PLACE OF BURIAL OR REMOVAL

Mt Olivet

DATE OF BURIAL

May 26, 1915

20-UNDERTAKER

Philip Henry Orleans

ADDRESS 2016

C85575

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 C85575
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Nursery & Child Hospital* 18 WARD)

2-FULL NAME

Residence in Baltimore: No. *Nursery & Child Hospital* St.: yrs. *3* mos. *5* ds.

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)

6-DATE OF BIRTH,

2 *19*, 19*15*
(Month) (Day) (Year)

7-AGE,

yrs. *9* mos. *5* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *none*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank J. Nettles*(Address) *Nursery & Child Hospital*

15-

MAY 25 1915 ROBERT KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 *24*, 19*15*.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 1* 1915, to *May 24* 1915, that I saw him alive on *May 24* 1915, and that death occurred, on the date stated above, at *9 A* m.

The CAUSE OF DEATH* was as follows:

Alimentary & Hemiparesis
(Succ. Melanation)
(Duration) ... yrs. ... mos. *24* ds.CONTRIBUTORY
(Secondary)(Duration) ... yrs. ... mos. ... ds.
(Signed) *E. Edgar B. Friedemann* D. D.
May 24 1915. (Address) *1616 Linden Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *9* mos. *4* ds. In the State yrs. ... mos. ... ds.Where was disease contracted, if not at place of death? *At Hospital.*

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

London Park Ave *May 26*, 1915*George Smith* *Bayette St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85576

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85576

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (Not for use in City of Baltimore) ST. 7 WARD)

2-FULL NAME George F. Turley

3-RESIDENCE: No. Winfield W. Va. St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

4-SEX

Male

5-COLOR OR RACE

White

6-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

7-DATE OF BIRTH

Mar 29, 1870
(Month) (Day) (Year)

8-AGE

45 yrs. mos. ds. or min.?

If LESS than 1 day, hrs.

9-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant
unknown

10-BIRTHPLACE
(State or country)

W. Va.

PARENTS

10-NAME OF FATHER

Benias Turley

11-BIRTHPLACE OF FATHER
(State or country)

W. Va.

12-MAIDEN NAME OF MOTHER

Sara Rice

13-BIRTHPLACE OF MOTHER
(State or country)

W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Abcurn

(Address)

J. H. Hoop

MAY 25 1915

ROBERT H. RAUTER,

Fun. 1915 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 13, 1915, to May 23, 1915.

that I saw him alive on May 23, 1915, and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma head of pancreas
(Operation + Post Op. Em.)

Contributory (SECONDARY) Gall Stone in common duct & perforation
Spermatitis (Duration) 1 yrs. 6 mos. ds.
(Signed) George R. Dunn M.D.
May 25, 1915 (Address) J. H. Hoop

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. 10 ds. State yrs. mos. 10 ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

Winfield W. Va.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Scary W. Va.

May 25, 1915

20-UNDERTAKER

ADDRESS

Albert C. Fuller

221 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85577

CERTIFICATE OF DEATH

151 C85577

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *1325 N Wolfe* ST. *8* WARD)

2 FULL NAME *Inf of Doris & Joseph Goldmann*

(Residence in Baltimore: No. *1325 N Wolfe* St. yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

May 24

1915

7 AGE

one hour

If LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Baltimore

10 NAME OF FATHER

Joseph Goldmann

11 BIRTHPLACE OF FATHER

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Dora Goldstein

13 BIRTHPLACE OF MOTHER

(State or country)

Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. Goldmann

(Address)

1325 N Wolfe

15 MAY 25 1915

ROBERT . KRAUTER,

Chief Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 24

1915

17 I HEREBY CERTIFY That I attended deceased from

May 24 - 10:15 PM

1915

that I saw him alive on *May 24*, 1915,

and that death occurred, on the date stated above, at *10 PM*.

The CAUSE OF DEATH* was as follows:

Pneumonia

Contributory (SECONDARY)

(Signed)

Dr. Kruger

191

(Address)

1028 N Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Hebrew Cemetery

DATE OF BURIAL

May 25 1915

20 UNDERTAKER

Jack Lewis

ADDRESS

1118 E. Pratt

HEALTH DEPARTMENT—CITY OF BALTIMORE

85578

CERTIFICATE OF DEATH.

170 85578

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *100 S Stricker* ST. *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Anna E. Wählner*(Residence in Baltimore: No. *100 S Stricker*St. *45* yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Unmarried*

6-DATE OF BIRTH,

June 16th, 1862
(Month) (Day) (Year)

7-AGE,

52 yrs. *11* mos. *7* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *House Wives*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Joseph T. Reinhardt

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Maria Biermann

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Wählner*.....(Address) *100 S Stricker St.*

15-

MAY 25 1915

ROBERT KRAUTER,

1st Deputy Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 23rd, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY. That I attended deceased from

*March 1, 1915, to May 23, 1915,*that I saw her alive on *May 23, 1915*and that death occurred, on the date stated above, at *8:45* p.m.

The CAUSE OF DEATH* was as follows:

Chronic Infection
Neuralgia of the(Duration) *1* yrs. *3* mos. *3* ds.

CONTRIBUTORY (Secondary)

Uræmia
(Duration) *1* yrs. *3* mos. *3* ds.(Signed) *Julius Fiedler* M. D.*May 25, 1915* (Address) *P.O. 131, Charles*

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Cemetery

DATE OF BURIAL,

May 24, 1915

20-UNDERTAKER

Mrs. Mrs. John H. Pfeiffer with Gayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085579

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

085579

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *509 Bloom* ST. *14* WARD)2-FULL NAME *Mary Dent*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RH out No. 18.)

(Residence in Baltimore: No. *509 Bloom* St. *12* yrs. *1* mo. *9* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE *Single*
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

6-DATE OF BIRTH *April 16, 1903*
 (Month) (Day) (Year)

7-AGE *12* yrs. *1* mo. *9* ds. or If LESS than 1 day, hrs. min.?

8-OCCUPATION
 (a) Trade, profession or particular kind of work *School Girl*
 (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
 (State or country) *Baltimore.*

10-NAME OF FATHER *Joseph Dent*

11-BIRTHPLACE OF FATHER
 (State or country) *Maryland*

12-MAIDEN NAME OF MOTHER *Mary Washington*

13-BIRTHPLACE OF MOTHER
 (State or country) *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Anna E. S. S.*(Address) *509 Bloom St.*

15-

MAY 25 1915

ROBERT . KRAUTER,

Burial Permit Clerk

REGISTRAR

J. P. M.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 25, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 23*, 1915, to *May 25*, 1915, that I saw her alive on *May 24*, 1915, and that death occurred, on the date stated above, at *7:45* A.M. The CAUSE OF DEATH* was as follows:

Scrub fever (Duration) *3* yrs. *3* mos. *3* ds.
 Contributory (SECONDARY) *Tonsillitis and*
typhoid (Duration) *3* yrs. *3* mos. *3* ds.
 (Signed) *Edward E. Hacking*
May 25th, 1915. [Address] *1339 N. North St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, If not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20-UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

885580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37

885580

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No

2-FULL NAME

Residence in Baltimore: No.

Maryland Penitentiary 16

Charles Starvey

1314 Riggs Avenue

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

June 27 1882

7-AGE

32 yrs. 10 mos. 23 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Waiter

9-BIRTHPLACE
(State or country)

Calvert Co Md.

10 NAME OF FATHER

James Harvey

11-BIRTHPLACE OF FATHER
(State or country)

Md.

12-MAIDEN NAME OF MOTHER

Priscilla Johnson

13-BIRTHPLACE OF MOTHER
(State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Address

Robert Krauter
1314 Riggs Avenue

15-

Filed MAY 25 1915 ROBERT KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 20 1915

17- I HEREBY CERTIFY, That I attended deceased from March 10 1914, to May 20 1915, that I saw him alive on May 20 1915, and that death occurred, on the date stated above, at 6:10 p.m.

The CAUSE OF DEATH* was as follows:

Toxemia + Exhaustion

Contributory (SECONDARY)

Ascomator Stavia

(Signed) William B. Stavia

5/21 1915 [Address] Md. Penitentiary

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death 1 yrs 4 mos 8 ds. In the State yrs mos ds.

Where was disease contracted, If not at place of death?

Former or usual residence 1314 Riggs Ave.

19-PLACE OF BURIAL OR REMOVAL

Mt Auburn

20-UNDERTAKER

Paul W. Chase & Son

DATE OF BURIAL

May 25 1915

ADDRESS

1400 Market St.

855581

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

855581

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *207 Ansquith* ST.; *5* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Augustus, Brooks*(Residence in Baltimore: No. *207 Ansquith* St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Unknown, 1

(Month)

(Day)

(Year)

7-AGE,

68

yrs. — mos. — ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE,

(State or Country), *md*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country), *md*

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country), *md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rev. D. G. Hill*(Address) *427 Mosher St*

15- MAY 25 1915

Filed..... 191.....

HARRY O. ANDERSON,

Burial Permit 0191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May**24**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 18 1915, to *May 24* 1915,that I saw him alive on *May 22* 1915,and that death occurred, on the date stated above, at *7 P* m.

The CAUSE OF DEATH* was as follows:

*Myocardial Insufficiency**unknown* (Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

Heart Failure (Duration)..... yrs. mos. ds.(Signed) *Edmund D. Fisher* M. D.*May 25* 1915. (Address) *1612 E. Monument*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

May 26, 1915

20-UNDERTAKER

ADDRESS

Theodore White *1702 Gough St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

85582

8

85582

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *923 Fill*)ST.: *K* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Frank Dombrowski(Residence in Baltimore: No. *923 Fill*)St.;yrs., 1 mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

March 31, 1915
(Month) (Day) (Year)

7-AGE,

1 mos. 24 ds.

If LESS than 1 day,

.....hrs. or.....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*none*9-BIRTHPLACE,
(State or Country).*Baltimore*

10-NAME OF FATHER,

*John Dombrowski*11-BIRTHPLACE OF FATHER
(State or Country),*Poland German*

12-MAIDEN NAME OF MOTHER

*Marie Barszok*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Marie Dombrowski*(Address) *923 Fill St.*

15-

MAY 25 1915

HARRY O. ANDREWS

Filed

191

Burial Permit 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 25, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 23 1915*, to *May 25 1915*, that I saw him alive on *May 25 1915*, and that death occurred, on the date stated above, at *2¹⁵ p. m.*
The CAUSE OF DEATH* was as follows:*Whooping Cough*(Duration).....yrs.....mos. *18* ds.CONTRIBUTORY
(Secondary)(Duration).....yrs.....mos. *18* ds.(Signed) *S. S. Sadowski, M. D.**May 25, 1915.* (Address) *722 S. Ann. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. In the State.....yrs.....mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

May 26, 1915

20-UNDERTAKER

M. F. Sadowski
over

ADDRESS

705 S. Ann. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Protestant* ST.; *14* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1002* *Winston Salem* *NB* St.; yrs. mos. *5* ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

Jan *15*, *1856*
(Month) (Day) (Year)

7-AGE,

57 yrs. *4* mos. *9* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Mr. Carolina

10-NAME OF FATHER,

George Holbrook

11-BIRTHPLACE OF FATHER (State or Country),

Mr. Carolina

12-MAIDEN NAME OF MOTHER

Elizabeth Linnell

13-BIRTHPLACE OF MOTHER (State or Country),

Mr. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Dr. J. D. Gray*(Address) *Winston Salem, N.C.*

15 MAY 25 1915

HARRY O. ANDREWS,

Filed. 191. Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May *24*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 20 *1915*, to *May 24* *1915*,that I saw her alive on *May 24* *1915*,and that death occurred, on the date stated above, at *4 P. M.*

The CAUSE OF DEATH* was as follows:

Osteomyelitis Tibia(Duration) *50* yrs. *0* mos. *0* ds.CONTRIBUTORY *Post-operative shock*
(Secondary)(Duration) *50* yrs. *0* mos. *0* ds.(Signed) *Edwin S. Davis* M. D.*May 24*, *1915*. (Address) *M.D.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *5* ds. State yrs. mos. *5* ds.Where was disease contracted, if not at place of death? *Winston Salem, N.C.*Former or usual residence *Winston Salem, N.C.*

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Winston Salem, N.C. *May 25* *1915*

20-UNDERTAKER ADDRESS

Joseph B. Cook *103 M. Bala.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

85584

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81

85584

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

ST.

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 60 yrs. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 25 1915

191

HARRY O. ANDREWS,

Barial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, an-

topsy or inquiry.) find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (old age)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. M. Savage, M. D.

(Coroner.) May 25, 1915 (Address) 1729 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

85585

HEALTH DEPARTMENT—CITY OF BALTIMORE

85585

85585

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 S. Milton Ave. ST. 1 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Eleonora Harris(Residence in Baltimore: No. 509 S. Milton Ave. St. 17 yrs. 9 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

Aug 6, 1897
(Month) (Day) (Year)

7-AGE,

17 yrs. 9 mos. 17 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Bundle Wrapper
Stewart

9-BIRTHPLACE, (State or Country),

Balto. Md.

PARENTS.

10-NAME OF FATHER,

Cornelius Harris

11-BIRTHPLACE OF FATHER (State or Country),

Balto. Md.

12-MAIDEN NAME OF MOTHER,

Minnie Seibert

13-BIRTHPLACE OF MOTHER (State or Country),

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Harris(Address) 509 S. Milton

MAY 25 1915

BARRY O. ALLENDAU,

Filed..... 191.. Serial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 12 1914, to May 23 1915.that I saw him alive on May 22 1915,and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Tuberculosis
(Duration)..... yrs. mos. ds.(Signed) Geo. H. Allen M. D.5.24, 1915 (Address) 1937 Gough St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

May 26, 1915.

20-UNDERTAKER

John A. Moran

ADDRESS

Bank

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085586

HEALTH DEPARTMENT—CITY OF BALTIMORE

085586

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1309 Morning Ave. 13

WARD)

2 FULL NAME

Baby Brown

(Residence in Baltimore: No. 1309 Morning Ave

St.:

yrs.

mos.

1 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

May 24, 1915

7 AGE

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9 BIRTHPLACE

(State or country)

Balto

10 NAME OF FATHER

Wm M. Brown

11 BIRTHPLACE OF FATHER
(State or country)

Balto,

12 MAIDEN NAME OF MOTHER

Minnie Wilson

13 BIRTHPLACE OF MOTHER
(State or country)

Balto Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm M. Brown

(Address)

1309 Morning Ave

15

MAY 25 1915

HARRY O. ANDREWS

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 25, 1915

17 I HEREBY CERTIFY, That I attended deceased from 5/24/1915 to 5/25/1915

that I saw her alive on 5/24/1915 and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH* was as follows:

6 mo. Miscarriage
(Premature Birth)

Contributory
(SECONDARY)

(Signed) Geo. W. to the Dr. M. D.
May 25, 1915 (Address) 2020 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Mary's Hospital

May 26, 1915

20 UNDERTAKER

ADDRESS

Cheney & Co. Baltimore

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

85587

91 85587

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 3105 Huntington Ave.

St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Donald H. Wolf

(Residence in Baltimore: No. 3105 Huntington Ave.

St. yrs. 10 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH July 23, 1914 (Month) (Day) (Year)

7-AGE 10 yrs. 1 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country)

Maryland (City)

10-NAME OF FATHER

Albert Wolf

11-BIRTHPLACE OF FATHER (State or country)

Pennsylvania

12-MAIDEN NAME OF MOTHER

Emma Shawberry

13-BIRTHPLACE OF MOTHER (State or country)

Pennsylvania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Albert Wolf

(Informant)

(Address) 3105 Huntington Ave.

15-MAY 25 1915

HARRY O. ANDREWS,

Registrar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 23, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 9th, 1915, to May 23rd, 1915,

that I saw him alive on May 23rd, 1915, and that death occurred, on the date stated above, at 9 A. m. The CAUSE OF DEATH* was as follows:

Cardiac Failure.

Few hours.

Contributory (SECONDARY)

Broncho-Pneumonia (Duration) yrs. mos. ds.

2 Weeks

(Signed),

R. A. Richardson M. D.

May 24th, 1915 (Address) 112 W. 25th. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Marys Hospital May 25, 1915

20-UNDERTAKER

ADDRESS

Chenworth & Son Chestnut Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

85588

85588

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *505 S Milton Ave* ST.; *1* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *505 S Milton Ave* St.; *—* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Nov 10, 18*38*
(Month) (Day) (Year)

7-AGE,

76 yrs., *6* mos., *14* ds.If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*at Home*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

*Lehard*11-BIRTHPLACE OF FATHER
(State or Country),*Lehard Germany*

12-MAIDEN NAME OF MOTHER

*not known*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thomas Herr*(Address) *505 S Milton Ave*

15-

MAY 25 1915

HARRY O. ANDREWS,

Filed *19* Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 24, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *May 23* 1915, to *May 24* 1915, that I saw her alive on *May 24* 1915, and that death occurred, on the date stated above, at *4:30* p.m. The CAUSE OF DEATH* was as follows:*Chronic Nephritis*(Duration) *Unknown* yrs., *—* mos., *—* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs., *—* mos., *—* ds.(Signed) *H. B. Titlow* M. D.*May 25*, 1915. (Address) *3035 Edmond*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

St. Carmel (Cen)

DATE OF BURIAL.

May 27 1915.

20-UNDERTAKER

L. Heumann

ADDRESS

32 S Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

85589

HEALTH DEPARTMENT—CITY OF BALTIMORE

85589

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *246* *Rock* ST. *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Georgie Carter*(Residence in Baltimore: No. *246* *Rock* ST. — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH.

*Unknown**1866*

(Month)

(Day)

(Year)

7-AGE.

49

— yrs. — mos. — ds.

If LESS than 1 day.

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Cook*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Ind

10-NAME OF FATHER.

Not known

11-BIRTHPLACE OF FATHER (State or Country)

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country).

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Carter*(Address) *246 Rock St*

MAY 25 1915

HARRY O. ANDREWS,

Filed.....

191.....

Bartol-Porritt, Oliver

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 24, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 19, 1915* to *May 24, 1915*.that I saw *him* alive on *May 24, 1915*.and that death occurred, on the date stated above, at *10:22* a.m.

The CAUSE OF DEATH* was as follows:

Asthma, Bronchitis, Bright's Disease(Duration) *3* yrs. *9* mos. *9* ds.

CONTRIBUTORY (Secondary)

Bright's Disease(Signed) *Dr. W. H. Kennedy*D. *May 25, 1915* (Address) *708 E. Main St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *9* mos. *9* ds. In the State *3* yrs. *9* mos. *9* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Mount Hope

DATE OF BURIAL.

May 26, 1915

20-UNDERTAKER

Daniel Easton

ADDRESS

916 Penna ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

85590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40
REGISTERED No. C

85590

PLACE OF DEATH

CITY OF BALTIMORE (No.

1719 Eastern Ave

ST. V

WARD)

FULL NAME

Andrew Jagoda

(Residence in Baltimore: No.

1719 Eastern Ave

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

21 yrs., 9 mos., 1 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

Unknown, 1872

(Month)

(Day)

(Year)

7-AGE,

43

yrs., 1 mos., 1 da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer).

At home

9-BIRTHPLACE,
(State or Country),

Austria

10-NAME OF FATHER,

John Jagoda

11-BIRTHPLACE OF FATHER
(State or Country),

Austria

12-MAIDEN NAME OF MOTHER,

Honorata Symonowicz

13-BIRTHPLACE OF MOTHER
(State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jena Jagoda

(Address)

1719 Eastern Ave

15 MAY 25 1915.

HARRY O. ANDREWS,

Filed

191

Bartal Permit. Clari Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 25, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
(Chronic Myocarditis)

(Duration) yrs. mos. da.

CONTRIBUTORY Cause of Death
(Secondary) attended by or without

(Duration) yrs. mos. da.

(Signed) David W. Jones M. D.

(Coroner)

May 25, 1915. (Address) 3116 O'Donnell St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

May 28 1915

20-UNDERTAKER

William J. Alkovek

ADDRESS,

1618 Eastern Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C 85591

104 85591
REGISTERED NO. C 85591

PLACE OF DEATH

CITY OF BALTIMORE (No. 1603 Canton Ave

ST. 2

WARD)

FULL NAME

Thomas Baron

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1603 Canton Ave

St. 2, 5 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, Nov 26, 1914
(Month) (Day) (Year)

7-AGE, 5 yrs. 5 mos. 29 ds.
If LESS than 1 day, ... hrs. or ... min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER, Wicenty Baron

11-BIRTHPLACE OF FATHER (State or Country), Galicia Austria

12-MAIDEN NAME OF MOTHER, Albina Broutowicz

13-BIRTHPLACE OF MOTHER (State or Country), Galicia Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wicenty Baron

(Address) 1603 Canton Ave

15- MAY 25 1915

HARRY O. ANDREWS

Filed, 1915

Marial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic Enteritis

(Duration) yrs. 1 mon. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 mon. 1 ds.

(Signed) J. J. Jones, M. D.
(Coroner.)

May 25, 1915 (Address) 3116 Oldenwell St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. 1 mon. 1 ds. In the State, yrs. 1 mon. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

May 26 1915

UNDERTAKER

William Fialkowski

ADDRESS

1618 Eastern Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85592

92 C85592

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 863 W. Franklin ST.: 17 WARD)

FULL NAME

(Residence in Baltimore: No. 863 W. Franklin St.: _____ yrs., _____ mos., _____ ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE. <u>Col.</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <u>Single</u> (Write the word)
6-DATE OF BIRTH. <u>Sept 28, 1914</u> (Month) (Day) (Year)		
7-AGE. <u>8</u> yrs., <u>4</u> mos., <u>4</u> ds.		IF LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE. (State or Country). <u>Balt. Md.</u>		
PARENTS.	10-NAME OF FATHER. <u>George Hardy</u>	
	11-BIRTHPLACE OF FATHER (State or Country). <u>Md.</u>	
	12-MAIDEN NAME OF MOTHER <u>Margaret Hobbs</u>	
	13-BIRTHPLACE OF MOTHER (State or Country). <u>Md.</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Hardy
(Address) 863 W. Franklin15- MAY 26 1915 ROBERT KRAUTER,
Serial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 25, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 20 1915, to May 25 1915, that I saw her alive on May 24 1915, and that death occurred, on the date stated above, at 24 m. The CAUSE OF DEATH* was as follows:
Tubercular Pneumonia
(Duration) 5 yrs., 5 mos., 6 ds.CONTRIBUTORY
(Secondary)(Signed) Wm. S. Shiple M. D.
May 25, 1915 (Address) 206 W. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, _____ yrs., _____ mos., _____ ds. In the State, _____ yrs., _____ mos., _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Auburn CemeteryMay 26, 1915

20-UNDERTAKER

ADDRESS

Walter Osborn235 Pine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

085593

CERTIFICATE OF DEATH.

28

085593

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 S. Bond ST.; 3 WARD)

2-FULL NAME

Margaret Holland

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 520 S. Bond St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

June 11th, 1874
(Month) (Day) (Year)

7-AGE,

40 yrs., 11 mos., 12 ds.

IF LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Balt. City M.d.

10-NAME OF FATHER,

Ger. Hoffmann

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Margaret Heintz

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Henry Holland

(Address)

520 S. Bond St.

15-

MAY 26 1915

ROBERT . KRAUTER,

Filed

191

Baltimore Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 30 1915, to May 23 1915,

that I saw her alive on May 22 1915,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular Laryngitis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia - Tubercular

(Duration) yrs. 12 mos. ds.

(Signed) J. H. C. M. M. D.

May 24, 1915. (Address) 125 S. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Baltimore Cemetery

DATE OF BURIAL,

May 30, 1915.

20-UNDERTAKER

H. Sander Sons

ADDRESS

1700 Bond St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85594

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 79 C85594

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *Howard A. Kelly* *Ward* St. *McC*, WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary Hempstone Hawles*

(Residence in Baltimore: No. *1418 Eutaw Place* St.: *Leesburg Va.* yrs. mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married.* (Write the word)

16-DATE OF DEATH *May 26*, 191*5*
(Month) (Day) (Year)

6-DATE OF BIRTH *Nov. 6*, 185*4*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 21*, 191*5*, to *May 26* - 191*5*, that I saw her alive on *May 25*, 191*5*, and that death occurred, on the date stated above, at *5:10 a.m.* The CAUSE OF DEATH* was as follows:
myocarditis

7-AGE *60* yrs. *7* mos. *19* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *None.* (b) General nature of industry, business, or establishment in which employed (or employer)

(Duration) *?* yrs. mos. ds.

9-BIRTHPLACE (State or country) *Leesburg Va.*

Contributory (SECONDARY) (Duration) yrs. mos. ds.

10-NAME OF FATHER *Hempstone*

(Signed) *Howard A. Kelly* M. D. *26 May, 1915* (Address) *1418 Eutaw Pl.*

11-BIRTHPLACE OF FATHER (State or country) *Md.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

12-MAIDEN NAME OF MOTHER *Mary Dade*

13-BIRTHPLACE OF MOTHER (State or country) *Md.*

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death yrs. mos. *4* ds. In the State yrs. mos. *4* ds.

(Informant) *C. S. Hawles*

Where was disease contracted. *Leesburg, Va.*

(Address) *Leesburg Va (mo.)*

If not at place of death? *Leesburg, Va.*

Former or usual residence *Leesburg - Va.*

15. MAY 26 1915

ROBERT . KRAUTH

19-PLACE OF BURIAL OR REMOVAL *Leesburg Va* DATE OF BURIAL *May 26, 1915*

Filed *May 26*, 191

Funeral Permit *Glenn*

UNDERTAKER

REGISTRAR

Chas. Mitchell (The) Robt. K. Fayette

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85595

CERTIFICATE OF DEATH

42 C85595

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (NO

ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH

AGE

If LESS than
1 day, hrs.
or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(State or country)

NAME OF FATHER

BIRTHPLACE OF FATHER
(State or country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(State or country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

FILE

MAY 26 1915

DEPT. KRAUTER,

Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

May 25, 1915

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

855596

CERTIFICATE OF DEATH

81 855596

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3002 Chelsea Ave St. 15 WARD)

2-FULL NAME

John N. Bash (Bash)

(Residence in Baltimore: No. 3002 Chelsea Ave St. 5 yrs. 1 mos. 1 da.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Unknown 1 (Month) (Day) (Year)

7-AGE

about 78

IF LESS than

1 day, hrs.,

yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Organist

9-BIRTHPLACE

(State or country)

Md.

10-NAME OF FATHER

Henry Bash

11-BIRTHPLACE OF FATHER

(State or country)

Md.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John N. Bash, Jr.

(Address)

3002 Chelsea Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 25th, 1915 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I attended deceased from

1905, to May 24th, 1915

that I saw him alive on May 24th, 1915

and that death occurred, on the date stated above, at 6:15 m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis, Chronic
dementia

(Duration) 10 yrs. 1 mos. 1 da.

Contributory (SECONDARY)

Renal insufficiency

(Duration) 6 yrs. 6 mos. 1 da.

(Signed)

Edw. W. W. W.

M. D.

May 25th, 1915 (Address) 2002 Chelsea Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Greenmount

DATE OF BURIAL

May 27, 1915

20-UNDERTAKER

W. J. Luckenbach

ADDRESS

North Pa

15-

MAY 26 1915

ROBERT J. KRAUTER,

Chief Clerk

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

85597.

151 85597.

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

2814 Woodbrook Ea.

ST. 13

WARD)

2-FULL NAME

Harry Page Hanna

(Residence in Baltimore: No.

2814 Woodbrook Ea.

St.

13

Ward

13

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and full reg. No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

May 9, 1915

(Month)

(Day)

(Year)

7-AGE

YRS.

mos.

ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or country)

Baltimore Md

10-NAME OF FATHER

Carroll Frank Hanna

11-BIRTHPLACE OF FATHER

(State or country)

Balto. Co.

12-MAIDEN NAME OF MOTHER

Helen Bitzer

13-BIRTHPLACE OF MOTHER

(State or country)

Baltimore Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carroll Frank Hanna

(Address)

2814 Woodbrook Ea.

16-DATE OF DEATH

May

21

1915

(Month)

(Day)

(Year)

17.

I HEREBY CERTIFY, That I attended deceased from

May 9, 1915 to May 21, 1915

that I saw him alive on May 21, 1915

and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Malnutrition

Contributory

(SECONDARY)

(Signed)

Dr. P. P. P.

May 25, 1915

(Address)

2814 Woodbrook Ea.

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pleasant Hill Cem

May 25, 1915

20-UNDERTAKER

ADDRESS

H. J. Tucker & Son

Penn & Bath

15.

MAY 26 1915

ROBERT J. KRAUTER,

Chief Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85598

CERTIFICATE OF DEATH.

91 C85598

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 East Pratt ST.; 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Nathan Sholomovich(Residence in Baltimore: No. 904 E. Pratt St.St.; yrs. 6 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Child

6-DATE OF BIRTH

Oct 29, 1914
(Month) (Day) (Year)

7-AGE

6 yrs. 26 mos. 26 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Baron Solomonovitch

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Goldie Shenberg

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Henry.....(Address).....1419 E. Pratt St......

15-

MAY 26 1915 ROBERT KRAUSE, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 26, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from
May 25 1915 to May 26 1915,
that I saw him alive on May 26 1915,
and that death occurred, on the date stated above, at 6:30 a.m.
The CAUSE OF DEATH* was as follows:Broncho-Pneumonia
(Duration).....7 hrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary)

(Signed).....W. H. Allen, M. D......
May 26, 1915. (Address).....1810 E. Pratt St......

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Workmen circle Interment Co., Inc., 1915

20-UNDERTAKER

ADDRESS

Jack Lewis1419 E. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85599 HEALTH DEPARTMENT—CITY OF BALTIMORE

C85599

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1550 N. Carey* ST. *15* WARD)2-FULL NAME *William Garrett*(Residence in Baltimore: No. *1550 N. Carey* St.: yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Unknown*, *1871*

(Month)

(Day)

(Year)

7-AGE, *44* yrs. — mos. — da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Fireman*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Virginia*10-NAME OF FATHER, *Samuel Kull*11-BIRTHPLACE OF FATHER (State or Country), *Samuel Kull*12-MAIDEN NAME OF MOTHER *Mary Garrett*13-BIRTHPLACE OF MOTHER (State or Country), *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Garrett*(Address) *1550 N. Carey*

15-

MAY 26 1915

Filed

191

ROBERT KRAUTH

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 25th*, 1915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 15th* 1915, to *May 25th* 1915,that I saw him alive on *May 25th* 1915,and that death occurred, on the date stated above, at *6:15 a m.*

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Chronic Bronchitis & Emphysema*

(Duration) yrs. mos. ds.

(Signed) *A. B. Blasco* M. D.*May 25th*, 191... (Address) *1805 Penna ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Not in Cemetery*DATE OF BURIAL, *May 27th*, 1915.20-UNDERTAKER, *J. A. Bishop*ADDRESS, *Office*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85600 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 505 N Glover

2-FULL NAME

John J Swift

(Residence in Baltimore) No. 505 N Glover

ST.

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

June 15, 1852 (Month) (Day) (Year)

7-AGE,

62 yrs., 11 mos., 9 da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Laborn

9-BIRTHPLACE, (State or Country),

md

10-NAME OF FATHER,

William Swift

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary A. Swift

(Address)

505 N Glover St

15-

MAY 26 1915

ROBERT KRAUTH

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 24, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull (Accident)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

Fall down Stairway

(Signed)

(Duration) yrs. mos. da.

Relian J. Russell M. D.

May 24, 1915 (Address) 423 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. da. State... yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Cathedral Cemetery

May 27, 1915

20-UNDERTAKER

ADDRESS

Wendell Appleton

372 Ann St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85601

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 Eutaw Place. ST. 14 WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Elizabeth Davidson.(Residence in Baltimore: No. 2102 Eutaw Place. St. 68 yrs. 8 mos. 12 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female. 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widow.
(Write the word.)

6-DATE OF BIRTH, September 12, 1846.
(Month) (Day) (Year)

7-AGE, 68 yrs. 8 mos. 12 da. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, D. C. Bride.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Mary Bayley.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jos. W. Shirley,(Address) Kate & Park Heights Aves.

15-

Filed

MAY 26 1915

ROBERT KRAFTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5 24, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1914, to May 24 1915, that I saw her alive on May 12 1915, and that death occurred, on the date stated above, at 12 A. m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(Duration) 2 yrs. 8 mos. 12 da.

CONTRIBUTORY Chronic Concomitant
(Secondary)

(Signed) Dr. J. E. Sullivan M. D.
May 24 1915 (Address) 2038 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 68 yrs. 8 mos. 12 da. In the State 68 yrs. 8 mos. 12 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery. DATE OF BURIAL, May, 26, 1915.

20-UNDERTAKER Stewart & Mowen Co., 108W. North Av. ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85602

CERTIFICATE OF DEATH.

37 C85602
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.; *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)

6-DATE OF BIRTH, *May 8th*, 1915. (Month) (Day) (Year)

7-AGE, If LESS than 1 day, yrs. mos. *14* ds. hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15- MAY 26 1915 ROBERT J. KRAUTER, Filed..... 191..... Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 23rd, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 8th* 1915, to *May 23rd* 1915, that I saw him alive on *May 23rd* 1915, and that death occurred, on the date stated above, at 5:30 P. m. The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration)..... yrs. mos. *14* ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *Cliver G. Hall* M. D. *May 24, 1915*. (Address) *1617 E. North Ave.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *14* ds. In the State yrs. mos. *14* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral *May 24, 1915*

20-UNDERTAKER

ADDRESS

M. Fahy & Sons of Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85603

CERTIFICATE OF DEATH

x 31 C85603

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and room No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

September 16, 1890
(Month) (Day) (Year)

7-AGE

24 yrs. 8 mos. 2 ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (for employer)

Bill. boy.

9-BIRTHPLACE

(State or country)

Front Royal, Virginia

10-NAME OF FATHER

Jake French

11-BIRTHPLACE OF FATHER

(State or country)

Canada

12-MAIDEN NAME OF MOTHER

Sarah Franklin

13-BIRTHPLACE OF MOTHER

(State or country)

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

MAY 26 1915

ROBERT . HARTMAN,

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May-18th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

February-4, 1915, to, May-18th, 1915,

that I saw him alive on May-18th, 1915,

and that death occurred, on the date stated above, at 11:35 A.M.

The CAUSE OF DEATH* was as follows:

Tubercula and Exhaustion.

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

Tubercular Peritonitis.

(Duration) yrs. mos. ds.

(Signed) William H. Schwartz M.D.

May-18, 1915 [Address] Md Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. 6 mos. 11 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence 130 W. North St. Hagerstown, Md.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL MAY 25 1915

20-UNDERTAKER

ADDRESS

FOR ANATOMICAL PURPOSES

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 S Ellwood ST., 1 WARD)

2-FULL NAME

Charles M. Luebben(Residence in Baltimore: No. 1205 S Ellwood ave. St.: 50 yrs., 50 mos., 50 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE,
MARRIED, divorced,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

Nov 5, 1858
(Month) (Day) (Year)

7-AGE.

56 yrs., 6 mos., 19 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Ship Carpenter9-BIRTHPLACE,
(State or Country),Germany

10-NAME OF FATHER,

John B. Luebben11-BIRTHPLACE OF FATHER
(State or Country).Germany

12-MAIDEN NAME OF MOTHER

Elizabeth A. Luebben13-BIRTHPLACE OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Luebben(Address) 1205 S Ellwood ave.

15-

MAY 26 1915

Filed

191

TOLSON

SHATTUCK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 24, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 20 1915, to May 24 1915, that I saw him alive on May 24 1915, and that death occurred, on the date stated above, at 10⁵³ a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) yrs. mos. 4 ds.CONTRIBUTORY
(Secondary)(Duration) yrs. mos. 7 ds.(Signed) H. B. T. Luebben M. D.May 24 1915. (Address) 303 S Odum St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn

DATE OF BURIAL,

May 27, 1915

ADDRESS

403 S. M. St.

20-UNDERTAKER

Lilly & Green

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *705 S. Montford* ST.; *1* WARD)

2-FULL NAME

Anton Gippnich

(If death occurred in a hospital or institution, give its NAME instead of street and number and All out No. 18.)

(Residence in Baltimore: No. *705 S. Montford Ave* St.; *60* yrs., — mon. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH.

April 17, 1842
(Month) (Day) (Year)

7-AGE.

73 yrs. *1* mos. *23* ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Joseph Gippnich

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Theresa Schults

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Anton Gippnich*(Address) *705 S. Montford Ave*

15-

Filed

MAY 26 1915

ROBERT KRAUTER,

BRIEFING PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 24, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 24* 1915, to *May 25* 1915, that I saw him alive on *May 25* 1915, and that death occurred, on the date stated above, at *8:15* p.m. The CAUSE OF DEATH* was as follows:
Cirrhosis of Liver
(Duration) *2* yrs. *2* mos. *23* ds.

CONTRIBUTORY (Secondary)

(Signed) *J. Valentin* M. D.
May 24 1915. (Address) *16 S. Montford*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *73* yrs. *1* mos. *23* ds. In the State *73* yrs. *1* mos. *23* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Most Holy Redeemer Am.

DATE OF BURIAL.

May 27 1915

20-UNDERTAKER

Lilly and Gailer

ADDRESS

403 S. Montford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 923 W. Saratoga ST. 18 WARD)

2-FULL NAME Emma Pickering

(Residence in Baltimore: No. 923 W. Saratoga St. yrs. mos. ds.)

REGISTERED NO. C85606

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH

(Month) (Day) (Year)

7-AGE

IF LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

MAY 26 1915

ROBERT KRAUTER, Registrar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 25, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 14, 1915, to, May 25, 1915.

that I saw him alive on May 21, 1915,

and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart and dropsy

(Duration) 2 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), Louis W. Knight M. D.

, 191 (Address) 414 W. Greene St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1022 Whetcoat ST.; 16 WARD)FULL NAME Charles Whitticor (Whitticor)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1022 Whetcoat St.;

yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

colored5-SINGLE, Infant
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May 20, 1915.
(Month) (Day) (Year)

7-AGE,

5 yrs. 5 mos. 5 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, None(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE,

(State or Country), Baltimore City10-NAME OF FATHER, Frank Whitticor11-BIRTHPLACE OF FATHER (State or Country), Annen County Co., Maryland12-MAIDEN NAME OF MOTHER Samuel Jones13-BIRTHPLACE OF MOTHER (State or Country), Ellicott City Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Whitticor(Address) 1022 Whetcoat St.

15

MAY 26 1915

ROBERT J. KRAUTER,

Burial Permit Clerk

Filed

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 25, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 25 1915, to May 25 1915,that I saw him alive on May 25 1915,and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Infantile convulsions
(Cause unknown)(Duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY

(Secondary)

(Duration) — yrs. — mos. — ds.(Signed) Chas. C. McCarthy, M. D.May 25, 1915 (Address) 706 N. St. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

-DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Wm. H. Chase & Co.1700 N. Charles St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last digit of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85608

C85608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *General Hospital* ST. WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *415 E. 9th St. Brooklyn N.Y.* St. yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Widowed

6-DATE OF BIRTH

March 1 (Day) (Year)

7-AGE

71 yrs. mos. ds.If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Retired Merchant*9-BIRTHPLACE,
(State or Country).*Brooklyn N.Y.*

10-NAME OF FATHER

*Robert Krauter*11-BIRTHPLACE OF FATHER
(State or Country).*Brooklyn N.Y.*

12-MAIDEN NAME OF MOTHER

*Don't know*13-BIRTHPLACE OF MOTHER
(State or Country).*Brooklyn N.Y.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William Becker

(Address)

Union Hill, N.J.

15-

MAY 26 1915

ROBERT . KRAUTER

Filed..... 191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 25 191*5* (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *May 4* 191*5*, to *May 25* 191*5*, that I saw him alive on *May 25* 191*5*, and that death occurred, on the date stated above, at *9:30* pm.

The CAUSE OF DEATH* was as follows:

*Ascending Pylo-nephrosis*CONTRIBUTORY
(Secondary)

(Signed)

May 25 191*5* (Address) *2nd Genl Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

415 E 9th Brooklyn N.Y.

19-PLACE OF BURIAL OR REMOVAL

Brooklyn New York

DATE OF BURIAL

May 26, 1915

20-UNDERTAKER

Mr Cook

ADDRESS

502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Dec. 17, 1839

7-AGE,

75 yrs. 5 mos. 8 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Miss Mary C. Hilberg

(Address) 3517 Roland Ave

15-MAY 26 1915

ROBERT J. KRAUTER

Filed

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 25, 1915

17- I HEREBY CERTIFY, That I attended deceased from

May 3, 1915, to May 20, 1915

that I saw him alive on May 27, 1915

and that death occurred, on the date stated above, at 12:00 A.M.

The CAUSE OF DEATH* was as follows:

Valvular heart
Aortic Stenosis
Triumphid regurgitant

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. W. H. H. M. D.

May 25 1915 (Address) 2020 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Woodlawn Cemetery May 28, 1915

20-UNDERTAKER

Horace Burgeson 3631 Fells Rd

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85610

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85610

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 8)

2-FULL NAME

(Residence in Baltimore: No. 4702 S. Bond St.

REGISTERED NO. C

WARD 3

(If death occurred in a hospital or institution, give its NAME instead of street and number and RR cut No. 18.)

St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

February

18

1915

(Month)

(Day)

(Year)

7-AGE

3

mos.

7

ds.

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None.

9-BIRTHPLACE
(State or country)

Balti - Ind

10-NAME OF FATHER

William Kaminski

11-BIRTHPLACE OF FATHER
(State or country)

Poland

12-MAIDEN NAME OF MOTHER

Josephine Cider

13-BIRTHPLACE OF MOTHER
(State or country)

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. Fleisher

(Address)

9. H. H.

15-

MAY 26 1915

ROBERT KRAUTER,

Corial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

25

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25, 1915, to May 25, 1915,

that I saw her alive on May 25, 1915,

and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Bronchial

(Duration)

yrs.

mos.

7

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed), J. F. Powers

M. D.

May 25, 1915 [Address] J. H. H.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

1

in the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

at home

Former or usual residence

702 S. Bond St.

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary

DATE OF BURIAL

May 27 1915

20-UNDERTAKER

Wm. Fialkowski

ADDRESS

1618 Eastern Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *111 N. Curley* ST.; *6* WARD)

REGISTERED NO. C

2-FULL NAME

Infant of Charles P. and Fredericka Leimbach

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *111 N. Curley* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *M* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *May 22, 1911*
(Month) (Day) (Year)7-AGE, *1* yr. mos. ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Charles P. Leimbach*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER, *Friederika Willner*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles P. Leimbach*(Address) *111 N. Curley*

15-

MAY 26 1915

HARRY O. ANDREWS,

101. *Bureau Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5/22/15, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

5/22/15 191, to *5/22/15* 191,that I saw him/her on *5/22/15* 191,and that death occurred, on the date stated above, at *4:00* p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Birth
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Friederick H. Hermann*
5/26/15 (Address) *2919 E. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Mary's, N.Y. Rd. May 26 1915

20-UNDERTAKER

ADDRESS

for garden of St. Mary's 217 S. Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85612

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85612

CERTIFICATE OF DEATH.

80

PLACE OF DEATH

CITY OF BALTIMORE (No. *1828 Greenmount Ave* St. *12* WARD)

FULL NAME *Katherine Creek*

(Residence in Baltimore: No. *1828 Greenmount Ave*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

April

13th

1862

7-AGE.

53

1

11

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

John Betz

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Katherine Meyer

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Durham Wagner

(Address).....

1222 Sargent St.

15-

MAY 26 1915

HARRY O. ANDREWS,

191. Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 24

1915

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.

(Inquest, au-

topsy or inquiry.) and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Angina Pectoris

(Duration) yrs. mos. ds.

(Signed) *Wm. M. Davis* M. D.

(Coroner.)

May 25, 1915 (Address) *1724 Madison Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mt. Olivet

DATE OF BURIAL,

May 28, 1915

20-UNDERTAKER

G. F. Walker

ADDRESS

723 W. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85613

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *21 W. 25th St* ST. *12* WARD)

2-FULL NAME

(Residence in Baltimore: No. *21 W. 25th St* St.: *78* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Not known. Not known, 1837.
(Month) (Day) (Year)

7-AGE,

78 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*House Wife*9-BIRTHPLACE,
(State or Country),*Baltimore Md.*

10-NAME OF FATHER,

*William Reside*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore Md.*

12-MAIDEN NAME OF MOTHER

*Mary Miles*13-BIRTHPLACE OF MOTHER
(State or Country),*Wales*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George A. Cairnes M.D.*(Address) *21 W. 25th St.*

15- MAY 26 1915

HARRY O. ANDREWS,

Filed..... 191... Burial Permit... 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 25th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 19th 1915, to May 25th 1915,
that I saw her alive on *May 25th 1915,*and that death occurred, on the date stated above, at *3 p.* m.

The CAUSE OF DEATH* was as follows:

Grav. pneumonia
Pulmonary Oedema
(Duration)..... yrs. mos. ds.CONTRIBUTORY
(Secondary)*Exhaustion*
(Duration)..... yrs. mos. ds.
(Signed)..... *C. H. Mitchell* M. D.
May 26th 1915 (Address)..... *9 E. Chase St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

St. Mary's Cemetery, Towans Md.

DATE OF BURIAL,

May 28th, 1915.

20-UNDERTAKER

Henry H. Jenkins & Sons, 1000 Richard St.

CAUSE OF DEATH IN plain language, as far as it may be properly obtained. Each statement in this certificate is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2928 E Balto. ST. 6 WARD)

2-FULL NAME Mary B. Sanner

(Residence in Baltimore: No. 2928 E Balto. ST. - yrs. - mos. - ds.)

REGISTERED NO. C 45

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH Apr., 1865 (Month) (Day) (Year)

7-AGE 50 yrs. - mos. - ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION None (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Ind.

PARENTS 10-NAME OF FATHER John F. Sanner 11-BIRTHPLACE OF FATHER (State or country) Ind. 12-MAIDEN NAME OF MOTHER Mary V. Healy 13-BIRTHPLACE OF MOTHER (State or country) Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alex. Sanner (Address) 2928 E Balto.

Filed MAY 26 1915 HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 25th, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I attended deceased from May 1, 1915, to May 25, 1915, that I saw her alive on May 24, 1915, and that death occurred on the date stated above, at 12 30 PM. The CAUSE OF DEATH* was as follows:

Clinical Diagnosis
Carcinoma of Parotid
(Duration) 2 yrs. - mos. - ds.

Contributory (SECONDARY) (Duration) - yrs. - mos. - ds. (Signed) J. Knox Gussley M. D. May 26, 1915 (Address) 2928 E Balto.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death - yrs. - mos. - ds. In the State - yrs. - mos. - ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Greenbathel Cem DATE OF BURIAL May 27, 1915

20-UNDERTAKER Libna. Moran ADDRESS Barb. f. anns

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85615

CERTIFICATE OF DEATH.

x 39

C85615

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *Mercy Hospital* ST. *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Weston W Va* St.; yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR

(Write the word.)

Single

6-DATE OF BIRTH.

Jan. 4, 1871
(Month) (Day) (Year)

7-AGE.

44 yrs. *4* mos. *22* ds.

If LESS than 1 day.

..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Carter

9-BIRTHPLACE.

(State or Country).

W Va

PARENTS.

10-NAME OF FATHER.

Abraham Limber

11-BIRTHPLACE OF FATHER

(State or Country).

W Va

12-MAIDEN NAME OF MOTHER

Elizabeth Corley

13-BIRTHPLACE OF MOTHER

(State or Country).

W Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Reverend Mercy H. H. H.*(Address) *Calvert St. 12*

15-

MAY 26 1915

HARRY O. ANDREWS,

Filed

191

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 26, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 1, 1915, to *May 26, 1915*,that I saw him alive on *May 26, 1915*,and that death occurred, on the date stated above, at *5:05 P. M.*

The CAUSE OF DEATH* was as follows:

*Carcinoma of Tongue**(Operation & Microscopic Exam.)*(Duration) *2 yrs. 10 mos. 4 ds.*

CONTRIBUTORY

(Secondary)

Bronchopneumonia(Duration) *1 yr. 10 mos. 4 ds.*(Signed) *Edward J. Smith* M. D.*May 26, 1915* (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *25* ds. In the State yrs. mos. *25* ds.

Where was disease contracted, if not at place of death?

Hospital W Va

Former or usual residence

Hospital W Va

19-PLACE OF BURIAL OR REMOVAL.

Weston W Va.

DATE OF BURIAL.

May 26, 1915

20-UNDERTAKER

Wm. W. Rounton

ADDRESS

231 N. Greene

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificate.

C85616

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85616

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

University Hospital

ST.;

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Madale French

(Residence in Baltimore: No.

736 1/2 W. Lexington

St.;

yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, Married
MARRIED, ~~but~~
WIDOWED,
OR DIVORCED, ?
(Write the word.)

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

48 yrs. 2 mos. 7 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Book Agent

9-BIRTHPLACE,
(State or Country),

Massachusetts

10-NAME OF FATHER,

Benjamin Thomas

11-BIRTHPLACE OF FATHER
(State or Country),

Mass.

12-MAIDEN NAME OF MOTHER

Lora Machon

13-BIRTHPLACE OF MOTHER
(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).

Hospital Record

(Address)

University Hospital

15-MAY 26 1915

HARRY O. ANDREWS,

Filed..... 1915..Burial..Permit..Oliver

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 - 26 - 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

5 - 22 - 1915, to 5 - 26 - 1915,

that I saw her alive on 5 - 26 - 1915,

and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)Acute Arteriosclerosis
(Duration).....yrs.....mos.....ds.

(Signed).....Quinn T. L. M. D.

5 - 26 - 1915 (Address).....Univ. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the 1 yrs. 2 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 736 1/2 W. Lexington St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Boston Mass. 5/27/15

20-UNDERTAKER

ADDRESS

Chas. F. Coane & Son 118 Wm. & Royal Ave.

C85617

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85617

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (NO. 1629 W. Mulberry ST. 19 WARD)2-FULL NAME Emma L. Holmes

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1629 W. Mulberry St. 19 yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH Unknown 1857
(Month) (Day) (Year)7-AGE 58 If LESS than 1 day, 1 hrs., 1 min.
yrs. mos. ds. or min.?8-OCCUPATION
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE (State or country) BaltoPARENTS
10-NAME OF FATHER Elias Diven
11-BIRTHPLACE OF FATHER (State or country) Md
12-MAIDEN NAME OF MOTHER Mary A Parsons
13-BIRTHPLACE OF MOTHER (State or country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J H Bell(Address) 328 N Fulton

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 26, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1914, to May 26, 1915,that I saw her alive on May 25, 1915, and that death occurred, on the date stated above, at 6:15 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum
(Chronic Dysentery)
(Duration) unknown yrs. 1 mos. 1 ds.Contributory (SECONDARY) Chronic Intestinal Nephritis
(Duration) unknown yrs. 1 mos. 1 ds.(Signed) Charles G. G. M. D.
May 26, 1915 [Address] 1611 W. Landon St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 1 yrs. 1 mos. 1 ds. In the 1 yrs. 1 mos. 1 ds. State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Landon Park

DATE OF BURIAL

May 28, 1915

20-UNDERTAKER

Wm Book

ADDRESS

502 E. North

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 26 1915
FiledHARRY O. ANDREWS,
Burial Permit Clerk
REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

85619

HEALTH DEPARTMENT--CITY OF BALTIMORE

85619

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *855 Raborg* St. *17* WARD)

2-FULL NAME *Mary J. Brines*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No. *855 Raborg* St. *4* yrs. *4* mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Cauc* 5-SINGLE *Married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *November 1*
(Month) (Day) (Year)

7-AGE *64* yrs. *4* mos. *4* ds. or min. *?*
If LESS than 1 day, hrs. min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *Laundress*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Kyrgyzia*

PARENTS
10-NAME OF FATHER *Thomas Peaker*
11-BIRTHPLACE OF FATHER (State or country) *Id*
12-MAIDEN NAME OF MOTHER *Mary Johnson*
13-BIRTHPLACE OF MOTHER (State or country) *Id*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Thos Hudgins*

(Address) *855 Raborg St*

MAY 27 1915

Filed

191

ROBERT KRAUTER

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *May 25, 1915*

(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Mc* *May 25, 1915* to, *May 25, 1915*

that I saw him alive on *May 24, 1915* and that death occurred, on the date stated above, at *8 A* m.

The CAUSE OF DEATH* was as follows:

Chronic Osteoarthritis
Leucemia
Asp. Ignorant. Aukle
Joint
(Duration) yrs. *2* mos. *4* ds.
Contributory (SECONDARY) *Cardiac Stenosis*

(Signature) *J. H. Howard*
May 25, 1915 (Address) *739 W. Fayette St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. *4* mos. *4* ds. State *4* yrs. *4* mos. *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Stephen's Church

May 27, 1915

20-UNDERTAKER

ADDRESS

Charles B. Jones

1112 St. Saratoga St

C85620

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 C85620

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Church Home & Infirmary

ST.:

WARD)

REGISTERED NO. C

2-FULL NAME

Minnie May Gerlach. (Gerlach)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1502 E Hoffman St

St.: 40 yrs. 6 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

October (Month) 31 (Day), 1874 (Year)

7-AGE,

40 yrs. 6 mos. 25 ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Carroll Co. Md.

10-NAME OF FATHER,

Josiah Schuler

11-BIRTHPLACE OF FATHER

(State or Country),

Carroll Co. Md.

12-MAIDEN NAME OF MOTHER

Lucinda Croll

13-BIRTHPLACE OF MOTHER

(State or Country),

Carroll Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry F. Gerlach

(Address) 1502 Hoffman St

15-

MAY 27 1915, ROBERT J. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 25, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 10 1915, to May 25 1915,

that I saw her alive on May 25 1915,

and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Easiness of living, to transverse colon
Operation, antiseptic & microscopic exam.

Unknown (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY

(Secondary)

Unknown (Duration) ... yrs. ... mos. ... ds.

(Signed) J. Davis Reichard M. D.

May 25, 1915. (Address) Church Home & Infirmary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 14 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1502 E Hoffman St.

19-PLACE OF BURIAL OR REMOVAL.

London Park

DATE OF BURIAL.

May 28 1915

20-UNDERTAKER

Girkler & Girkler

ADDRESS

1739 E. Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85621

CERTIFICATE OF DEATH.

89 C85621

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 577 N. Central Ave. ST.; 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. 517 N. Central Ave. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Black5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Married

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

36 yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
-
- (b) General nature of industry, business, or establishment in which employed (or employer).....

Laborer
General9-BIRTHPLACE,
(State or Country),Md.

10-NAME OF FATHER,

Water Monroe11-BIRTHPLACE OF FATHER
(State or Country),Md.

12-MAIDEN NAME OF MOTHER

Emily Whalen13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Victoria Morgan

(Address),

708 N. Caroline St.

15-

MAY 27 1915

ROBERT . KRAUTER

Filed.....

191.....

Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 25, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 18, 1915, to May 25, 1915.that I saw him alive on May 24, 1915,and that death occurred, on the date stated above, at 3 9, m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

.....

.....

..... (Duration)..... yrs. mos. ds.

CONTRIBUTORY.....
(Secondary).....

..... (Duration)..... yrs. mos. ds.

(Signed)..... M. D.
5/26/15 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Burial Cemetery

DATE OF BURIAL,

May 27, 1915

20-UNDERTAKER,

Robert A. Elliott

ADDRESS

508 Rogers Ave

CAUSE OF DEATH in plain terms, so that it may be properly translated. Last statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

104 C85622

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

23 S. Front

ST. 3

WARD)

2-FULL NAME

Carmelo Ciaffo

(Residence in Baltimore: No.

23 S. Front

St.:

yrs. 2

mos. 3

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and full out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Mar 23, 1915

(Month)

(Day)

(Year)

7-AGE

yrs. 2 mos. 3 ds.

IF LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Baltimore city

10-NAME OF FATHER

Pacifico Ciaffo

11-BIRTHPLACE OF FATHER

(State or country)

Italy

12-MAIDEN NAME OF MOTHER

Lidia Pavona

13-BIRTHPLACE OF MOTHER

(State or country)

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Pacifico Ciaffo

(Address)

23 S. Front St

15 MAY 27 1915

ROBERT J. KRAUTER,

Filed

191

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 26, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 19, 1915, to May 24, 1915.

that I saw him alive on May 24, 1915,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration)

yrs.

mos. 10

ds.

Contributory (SECONDARY)

Meningitis (simple)

(Duration)

yrs.

mos. 5

ds.

(Signed)

John L. Ottaviano M. D.

May 26, 1915

(Address)

1038 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

H. Vincent

DATE OF BURIAL

May 27, 1915

20-UNDERTAKER

W. J. Schaeffer & Son

ADDRESS

815 S. Front St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85623

C85623

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST. 17 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-STATUS

~~SINGLE~~

~~MARRIED~~

~~WIDOWED~~

~~WORKED~~

(Write the word)

widowed

6-DATE OF BIRTH

July

24, 1854

7-AGE

60 yrs. 10 mos. 25 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Plasterer

9-BIRTHPLACE
(State or country)

North Carolina

10-NAME OF FATHER

Apel

PARENTS

11-BIRTHPLACE OF FATHER
(State or country)

unknown

12-MAIDEN NAME OF MOTHER

B. V. Waltermeyer

13-BIRTHPLACE OF MOTHER
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Josephine Reilly (Supt.)

(Address)

200 West 21 St.

15

MAY 23 1915

ROBERT J. KRAUTER

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

24, 1915

17- I HEREBY CERTIFY, That I attended deceased from

May 17, 1915, to May 24, 1915.

that I saw him alive on May 23, 1915.

and that death occurred, on the date stated above, at 4:50 p.m.

The CAUSE OF DEATH* was as follows:

Chronic
Interstrial Nephritis
(Systemic Exema)

(Duration) 2 yrs. 3 mos. 6 ds.

Contributory Uremia Convulsions

(SECONDARY) (Duration) yrs. 3 mos. 3 ds.

(Signed) Geo. H. Egan M.D.

May 24, 1915 (Address) 100 W 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 7 mos. 7 ds. In the State 60 yrs. 3 mos. 3 ds.

Where was disease contracted?

If not at place of death? Mt. Vernon Bldg Co. Md.

Former or usual residence Mt. Vernon

19-PLACE OF BURIAL OR REMOVAL

Balto Cem

20-UNDERTAKER

W. J. Tichenor

DATE OF BURIAL

May 27, 1915

ADDRESS

Camden Office
SC.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85624

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 E North ST.; 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1824 E North St.; 8 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, Not Known, 1 1915 (Month) (Day) (Year)7-AGE, about 53 yrs. mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, Shoe Fitter. (b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, Samuel Burns11-BIRTHPLACE OF FATHER (State or Country), Eastern Shore Md12-MAIDEN NAME OF MOTHER, Mary Jane Mills13-BIRTHPLACE OF MOTHER (State or Country), Eastern Shore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Mr. Mary Sherman(Address), 1824 E North15- MAY 27 1915 ROBERT . KRAUTER

Filed....., 191. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 31 1915, to May 26 1915, that I saw her alive on May 26 1915, and that death occurred, on the date stated above, at 4 P. m. The CAUSE OF DEATH* was as follows:Cancer of Uterus
(Blind)
(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary).....

(Signed) William J. Watson M. D. May 27, 1915. (Address) 5128 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. VincentDATE OF BURIAL, May 27 191520-UNDERTAKER, William Cook

ADDRESS.....

COPIES OF DEATH IN plain text, so that it may be properly examined. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85625

CERTIFICATE OF DEATH.

79 C85625

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *1111 Russell* ST.; *21* WARD)

2—FULL NAME

(Residence in Baltimore: No. *1111 Russell* St. *50* yrs., mos. ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3—SEX, *Male* 4—COLOR OR RACE, *White* 5—SINGLE, *MARRIED*, *WIDOWED*, *OR DIVORCED*, *widow*
(Write the word.)6—DATE OF BIRTH, *Sept. 11*, 1915
(Month) (Day) (Year)7—AGE, *about 77* yrs., mos. ds. If LESS than 1 day, ... hrs. or ... min.?8—OCCUPATION:
(a) Trade, profession, or particular kind of work, *Nothing*
(b) General nature of industry, business, or establishment in which employed (or employer).9—BIRTHPLACE, (State or Country), *Germany*10—NAME OF FATHER, *Unknown*11—BIRTHPLACE OF FATHER (State or Country), *Germany*12—MAIDEN NAME OF MOTHER, *Unknown*13—BIRTHPLACE OF MOTHER (State or Country), *Germany*

14—THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Roth*(Address) *1111 Russell St*15—*MAY 27 1915* ROBERT J. KRAUTERFiled *1915* Burial Permitt. Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16—DATE OF DEATH *May 25*, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *May 10* 1915, to *May 25* 1915, that I saw him alive on *May 24* 1915, and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

Initial Respiratory
Spasmodic Asthma
(Duration) *1* yrs., mos. ds.CONTRIBUTORY *Anasore*
(Secondary)(Signed) *W. H. Hammersbach* M. D.
May 25, 1915. (Address) *835 Light St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18—LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19—PLACE OF BURIAL OR REMOVAL,

Louder Park

DATE OF BURIAL,

May 27, 1915

20—UNDERTAKER

W. Cook

ADDRESS

502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85626

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Wiley Hospital* ST. *4* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Low Point* St. *md* yrs. *8* mo. *8* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word.) *Single*

6-DATE OF BIRTH,

July 19, 1852
(Month) (Day) (Year)

7-AGE,

62 yrs. *10* mos. *8* da.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Fisherman*9-BIRTHPLACE,
(State or Country),*md*

10-NAME OF FATHER,

*John S. Slicer*11-BIRTHPLACE OF FATHER
(State or Country),*Va*

12-MAIDEN NAME OF MOTHER

*Sarah Ann Clark*13-BIRTHPLACE OF MOTHER
(State or Country),*Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert M. Kraut*(Address) *Low Point*

15-

MAY 27 1915

ROBERT M. KRAUT

Filed *1915* Burial Permit *1915*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 27, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 19, 1915*, to *May 27, 1915*, that I saw him alive on *May 27, 1915*, and that death occurred, on the date stated above, at *4:00 p.m.*

The CAUSE OF DEATH* was as follows:

Myocarditis
(Duration) *Do not know* yrs. *0* mos. *0* da.
CONTRIBUTORY (Secondary) *Ch. of Arteriosclerosis*
(Duration) *Do not know* yrs. *0* mos. *0* da.
(Signed) *Robert M. Kraut* M. D.
May 27, 1915 (Address) *Low Point*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *8* yrs. *0* mos. *0* da. In the *md* State *md* yrs. *0* mos. *0* da.Where was disease contracted, if not at place of death? *Low Point md*Former or usual residence *Low Point*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Low Point *May 27, 1915*

20-UNDERTAKER

ADDRESS

Low Point *12 N. Green*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85627

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85627

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1416 W. Mount ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RR cut No. 10.)

3-FULL NAME

(Residence in Baltimore: No. 1416 W. Mount St. 8 yrs. 8 mos. 15 da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Col.

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Chis.

6-DATE OF BIRTH

July 4, 1904
(Month) (Day) (Year)

7-AGE

10 yrs. 10 mos. 21 ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

School Boy

9-BIRTHPLACE
(State or country)

Baltimore Md

10-NAME OF FATHER

Thomas John Lynn

11-BIRTHPLACE OF FATHER
(State or country)

Montgomery Co Md

12-MAIDEN NAME OF MOTHER

Martha Ellen Reid

13-BIRTHPLACE OF MOTHER
(State or country)

Lexington Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Lynn

(Address) 1416 Mount

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

May 25, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 12, 1915, to, May 25, 1915, that I saw him alive on May 24, 1915, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Subsided Peritonitis & Cervical Glands
(Duration) 5 mos. 2 ds.

Contributory
(SECONDARY)

(Signed) Dr. J. H. Morgan M.D.
May 25, 1915 [Address] 1209 P. St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSPORTS, OR RECENT RESIDENTS]

At place of death 10 yrs. 10 mos. 21 ds. In the 15 State 8 yrs. 8 mos. 15 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt Auburn

DATE OF BURIAL

May 27, 1915

20-UNDERTAKER

James H. Dorn

ADDRESS

1303 Reisterstown

15-MAY 27 1915 ROBERT J. KRAUTER, Burial Permit Clerk REGISTRAR

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85628 HEALTH DEPARTMENT—CITY OF BALTIMORE

C85628

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1619 Division street, St. 14 WARD)

FULL NAME Upton Roberts,

(Residence in Baltimore: No. 1619 Division street, St.: yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, Married, WIDOWER, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, November 18th, 1859, (Month) (Day) (Year)

7-AGE, 55 yrs., 6 mos., 7 ds., 11 LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Private waiter, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland,

10-NAME OF FATHER, Lloyd Roberts,

11-BIRTHPLACE OF FATHER, (State or Country), Maryland,

12-MAIDEN NAME OF MOTHER, Unknown,

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. Cordelia Roberts, wife, (Informant)

(Address) 1619 Division street.

15 MAY 27 1915 ROBERT KRAUTER, Filled, 191. Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, May 25th, 1915, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Houder, M. D. (Coroner.)

May 25, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery, DATE OF BURIAL, May 28 1915

20-UNDERTAKER, George H. Holland, ADDRESS 577 Robert St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85629

CERTIFICATE OF DEATH.

79 C85629
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1225 St Mathan* ST.; *5* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1225 St Mathan* St.; yrs., mos. *2* / *4* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *(Married)*
(Write the word.)

6-DATE OF BIRTH. *May*, *1889*
(Month) (Day) (Year)

7-AGE, *26* yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Tailor*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Russia*

PARENTS.
10-NAME OF FATHER, *Abraham Flap*
11-BIRTHPLACE OF FATHER (State or Country), *Russia*
12-MAIDEN NAME OF MOTHER, *Sarah L. Brown*
13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Lewis*
(Address) *1419 E. Baltimore St.*

15 MAY 27 1915 ROBERT KRAUTER, Registrar.
Filed..... 191... *Bureau Permit Clerk*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May*, *27*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 3* 1915, to *May 22* 1915, that I saw him alive on *May 22* 1915, and that death occurred, on the date stated above, at *8:30 a.m.*
The CAUSE OF DEATH* was as follows:

Mitral & aortic insufficiency.
(Duration) *5* yrs. — mos. — ds.

CONTRIBUTORY *Pulmonary & aortic*
(Secondary)

(Duration) *7* yrs. — mos. — ds.
(Signed) *Harry Adler* M. D.
May 27, 1915 (Address) *1718 E. Baltimore Place*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. — mos. — ds. State yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Hehrem Herring Run* DATE OF BURIAL, *5/27, 1915*

20-UNDERTAKER *Jack Lewis* ADDRESS *1419 E. Baltimore*

CAUSE OF DEATH in plain terms, as far as it may be properly explained. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85630

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50

C85630

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3600 Garrison Ave.* ST. *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *3600 Garrison Ave.*St. *60* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED, MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Nov unknown 1849
(Month) (Day) (Year)

7-AGE,

65 yrs. 6 mos. — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

Reverend in
April Tax Court

9-BIRTHPLACE,

(State or Country),

Ohio

10-NAME OF FATHER,

Robt Rhodes

11-BIRTHPLACE OF FATHER

(State or Country),

Ohio

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Mary E. Rhodes

(Address)

3600 Garrison Ave

15-

MAY 27 1915

DANIEL O. ANDREWS,

Filed

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 27, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*April 20 1915, to May 27 1915,*that I saw him alive on *May 26 1915,*and that death occurred, on the date stated above, at *6.0* m.

The CAUSE OF DEATH* was as follows:

Coronary Calcification

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY

(Secondary)

Coronary Calcification + Diabetes

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Wm. H. Thompson* M. D.*May 27 1915* (Address) *2806 Garrison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn

DATE OF BURIAL,

May 28, 1915

20-UNDERTAKER

G. J. Walker

ADDRESS

*7230 Ray Ave**In a death certificate*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85631

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *802 East 22nd* ST.; *9* WARD)

2-FULL NAME

Mavis O. Holland(Residence in Baltimore: No. *802 East 22nd* St.; *9* yrs., *10* mos., *11* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, *mailed*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

June 30, 1860
(Month) (Day) (Year)

7-AGE

54 yrs. 10 mos. 26 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

At Home

9-BIRTHPLACE

(State or Country),

Baltimore City

10-NAME OF FATHER

Matthew O. Correa

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore City

12-MAIDEN NAME OF MOTHER

Barah A. Streadway

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lewis B. Holland*(Address) *802 E. Twenty Second*

15-

MAY 27 1915

Filed

191

*DANIEL O. ANDREWS**Bureau of Health*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 26, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

April 10, 1915 to *May 26, 1915*that I saw her alive on *May 26, 1915*and that death occurred, on the date stated above, at *8 1/2* p. m.

The CAUSE OF DEATH* was as follows:

*Cerebral Tumor**7* (Duration) *7* mos. *2* ds.CONTRIBUTORY (Secondary) *Hemiplegia**7* (Duration) *7* mos. *5* ds.(Signed) *Dr. H. A. Meyer* M. D.*May 27, 1915* (Address) *1031 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *7* yrs. *10* mos. *26* ds. In the State *7* yrs. *10* mos. *26* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Greenwood *May 27, 1915*

20-UNDERTAKER ADDRESS

William Cook *507 E. High*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85632

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE

MARRIED, 1

WIDOWED, 1

OR DIVORCED, 1

(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MAY 27 1915

HARRY O. ANDREWS,

Surficial Health Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

May 16 1915, to May 25 1915,

that I saw her alive on May 25 1915,

and that death occurred, on the date stated above, at 800 P.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

about 12 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward J. Smith, M. D.

May 25 1915 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 944 N. Baltimore St.

Former or usual residence 944 N. Baltimore St.

19-PLACE OF BURIAL OR REMOVAL, St. Peter's

DATE OF BURIAL,

May 28, 1915.

20-UNDERTAKER

ADDRESS

John Fields 1200 W. Lombard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85633

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85633

PLACE OF DEATH *St. Francis Convent*

CERTIFICATE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *Car Forrest & Chase* ST. *10* WARD)

2-FULL NAME *Sister Isabella M. Nelson*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *Car Forrest & Chase* St. *3* yrs. *3* mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*

4-COLOR OR RACE *Colored*

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) *Single*

6-DATE OF BIRTH *Dec - 25, 1895*

(Month) (Day) (Year)

7-AGE *19* yrs. *8* mos. *2* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work *Seamstress*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Washington D.C.*

10-NAME OF FATHER *James Nelson*

11-BIRTHPLACE OF FATHER (State or country) *Washington D.C.*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or country) *Washington D.C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Walter Mary Frances Chase St. & Forrest Place.*

(Address) *St. Francis Convent.*

15

MAY 27 1915

HARRY O. ANDREWS

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 27, 1915*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *Jan 1913* to *May 27, 1915*.

that I saw her alive on *May 14, 1915*.

and that death occurred, on the date stated above, at *8:5 a m.*

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(Duration) *2* yrs. *3* mos. *3* ds.

Contributory (SECONDARY)

(Duration) *3* yrs. *3* mos. *3* ds.

(Signed) *Mary F. Voeglein* M. D.
May 27, 1915 (Address) *1024 Valley St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *3* yrs. *3* mos. *3* ds. In the State *3* yrs. *3* mos. *3* ds.

Where was disease contracted, If not at place of death? *St. Francis Convent*

Former or usual residence *St. Francis Convent*

19-PLACE OF BURIAL OR REMOVAL *Cathedral Cemetery*

DATE OF BURIAL *May 27, 1915*

20-UNDERTAKER *Felix B. Pye*

ADDRESS *1024 Valley St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *WARD*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *26 Pearl St* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH

Unknown, 1842
(Month) (Day) (Year)

7-AGE

73 yrs. — mos. — ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

Clerk
*BROOK*9-BIRTHPLACE,
(State or Country),*Maryland*10-NAME OF
FATHER,*John Swickert*11-BIRTHPLACE
OF FATHER

(State or Country),

*Germany*12-MAIDEN NAME
OF MOTHER*Mary Keller*13-BIRTHPLACE
OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 27 1915

HARRY O. ANDREWS,

Filed

191

MAY 27 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 27, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 21, 1915 to May 27, 1915
that I saw him alive on *May 27* 1915and that death occurred, on the date stated above, at *3-28 P.M.*

The CAUSE OF DEATH* was as follows:

Cachexia(Duration) *7 yrs. 3 mos. — ds.*

CONTRIBUTORY

(Secondary)

Right Parotid Gland (Duration) *10 yrs. 10 mos. — ds.*(Signed) *R. L. Johnson* M. D.*May 27, 1915* (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *— yrs. — mos. 6 ds.* In the *73 yrs. — mos. 2 ds.* State

Where was disease contracted, if not at place of death?

Former or usual residence *26 Pearl St. Baltimore*

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

May 31, 1915

20-UNDERTAKER

G. J. Walker

ADDRESS

13 W. Bay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Date entered on back of certificate. important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C85635

CERTIFICATE OF DEATH

C85635

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

Str.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on and that death occurred, on the date stated above, at

The CAUSE OF DEATH was as follows:

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

MAY 27 1915

Filed

191

HARRY O. ANDREWS

Burial Permit Clerk

REGISTRAR

Baltimore cemetery May 28 1915
Liston P. Fasselbaugh 2620 St. Paul St.

N.B.—Every item of information should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85636

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85636

CERTIFICATE OF DEATH

142

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #71 Brick Hill St.: 13 WARD)

2-FULL NAME Margaret A. Helms

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No. # 71 Brick Hill St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED Widow
(Write the word)

6-DATE OF BIRTH Aug. 15, 1858
(Month) (Day) (Year)

7-AGE 56 yrs. 9 mos. 11 ds. or — min. If LESS than 1 day, — hrs., — min.?

8-OCCUPATION (a) Trade, profession or particular kind of work AT HOME
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto. Co. Md.

PARENTS	10-NAME OF FATHER	<u>ASKED & not given</u>
	11-BIRTHPLACE OF FATHER (State or country)	<u>Asked & not Given</u>
	12-MAIDEN NAME OF MOTHER	<u>Asked & not given</u>
	13-BIRTHPLACE OF MOTHER (State or country)	<u>Asked & not given</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Helms
(Address) #71 Brick Hill

15- MAY 27 1915 HARRY O. ANDREWS,
Filed 191 Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 26, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 23, 1915, to, May 26, 1915, that I saw her alive on May 25, 1915, and that death occurred, on the date stated above, at 5:40 a.m. The CAUSE OF DEATH* was as follows:

Lack of Circulation. Oldema phlebitis
& Sanguin

Contributory (SECONDARY) Infermitas
(Duration) 2 yrs. — mos. — ds.

(Signed) R.P. Casman M.D.
May 27, 1915 [Address] 1207 N. Carroll

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Loudon Park DATE OF BURIAL May 28 1915

20-UNDERTAKER A.S. Marshall ADDRESS 3539 Falls Road

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1103* *Berkeley*

2-FULL NAME

Batherine Key(Residence in Baltimore: No. *1103* *Berkeley*—

REGISTERED NO. C

ST.; *11* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *89* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Blk.

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH,

Jan 1

(Month)

(Day)

(Year)

7-AGE,

89

yrs.

mos.

ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laundress -

9-BIRTHPLACE,

(State or Country),

St. Mary's County Md.

10-NAME OF FATHER,

Isaac Miller

11-BIRTHPLACE OF FATHER

(State or Country),

MD

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER

(State or Country),

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lillian Mc Key*(Address) *1103 Berkeley*

15-

MAY 28 1915

ROBERT . KRAUTER,

Filed.

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May**26**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 13

1915, to

May 26

1915,

that I saw her alive on

May 25

1915,

and that death occurred, on the date stated above, at *12 noon*

The CAUSE OF DEATH* was as follows:

Mitral insufficiency with loss of compensation

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Betha E. Tappan* M. D.*May 26*, 1915 (Address) *2733 York Road*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Ann**May 28*, 1915.

20-UNDERTAKER

ADDRESS

*R L Parker**2741 320*

C85638

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85638

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

829 S. Bond

ST.:

WARD)

REGISTERED NO. C

2-FULL NAME

Stanislaus Turkos

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No.

829 So. Bond

St.:

yrs. 10 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

July

(Month)

8

(Day)

1914

(Year)

7-AGE.

10

19

ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

Baltimore

10-NAME OF FATHER.

Joseph Turkos

11-BIRTHPLACE OF FATHER
(State or Country)

Austria Poland

12-MAIDEN NAME OF MOTHER

Agnes Koppen

13-BIRTHPLACE OF MOTHER
(State or Country).

Austria Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph Turkos

(Address)

829 S. Bond St.

15-

MAY 28 1915

ROBERT . KRAUTER

SPECIAL PERMITS OFFICER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May

27

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 24 1915

to May 26 1915

that I saw him alive on May 26 1915, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis & shock

CONTRIBUTORY
(Secondary)

Broncho Pneumonia

(Signed)

Henry A. Rutledge

M. D.

1065/27 1915

(Address)

106 Jackson Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

St. Stanislaus

DATE OF BURIAL.

May 28, 1915

20-UNDERTAKER

M. Sadowicki

ADDRESS

905 So. Union St.

CAUSE OF DEATH in plain terms, so that it may be properly examined. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 C85639
REGISTERED NO. C.

PLACE OF DEATH

CITY OF BALTIMORE (No. 608 Washington ST. 2 WARD)

FULL NAME Mary Muczynski

(Residence in Baltimore: No. 608 Washington St. yrs. 25 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, (Month) (Day) (Year) 1862

7-AGE, 53 yrs. 1 mon. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Stair (b) General nature of industry, business, or establishment in which employed (or employer), at home

9-BIRTHPLACE, (State or Country), Germany

PARENTS. 10-NAME OF FATHER, Not known 11-BIRTHPLACE OF FATHER (State or Country), Not known 12-MAIDEN NAME OF MOTHER, Not known 13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Froski

(Address) 608 Washington St.

15- MAY 28 1915 ROBERT J. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis (Duration) about 6 yrs. 6 mos. 1 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) D. W. Jones, M. D. (Coroner.) May 27 1915 (Address) 316 Oxford St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus DATE OF BURIAL, May 29, 1915

20-UNDERTAKER, M. J. Sadowski ADDRESS, 700 St. Louis St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85610

CERTIFICATE OF DEATH.

170 C85610

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 E. Madison ST.; 7 WARD)

2-FULL NAME

Susan B. Blanchard

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1720 E. Madison St.; yrs. 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed (Write the word.)

6-DATE OF BIRTH, October 14, 1838 (Month) (Day) (Year)

7-AGE, 76 yrs. 7 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, at home (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Lorain Waterford - Vermont

10-NAME OF FATHER, Ralph Bugbee

11-BIRTHPLACE OF FATHER (State or Country), Conn

12-MAIDEN NAME OF MOTHER, Irene Goss

13-BIRTHPLACE OF MOTHER (State or Country), Lorain Waterford - Vermont

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Miss Irene M. Blanchard

(Address), 1720 E. Madison St.

15-MAY 28 1915 ROBERT . KRAUTER,

Filed..... 191.. Burial Permt. Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20 1915, to May 26 1915, that I saw her alive on May 24 1915, and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Nephritis (Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration)..... yrs. mos. ds.

(Signed) Chas. B. Rogers M. D. May 27, 1915. (Address) 834 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bloomington Ill.

DATE OF BURIAL, May 28, 1915.

20-UNDERTAKER, Henry W. Means

ADDRESS, 205 N. Calvert

CAUSE OF DEATH in plain terms, as far as it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85641

HEALTH DEPARTMENT—CITY OF BALTIMORE

170

C85641

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *871 Hanover*)

ST. *22* WARD)

2 FULL NAME

Louisa A. Leibold

(If death occurred in a hospital or institution, give its NAME instead of street and number and MH out No. 1A.)

(Residence in Baltimore: No. *871 Hanover*)

St. *Lifeline* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow*
(Write the word)

6 DATE OF BIRTH *Jan 1, 1850*
(Month) (Day) (Year)

7 AGE *65* yrs. *4* mos. *27* ds. or min. ?
If LESS than 1 day, hrs.

8 OCCUPATION *None*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Maryland*

10 NAME OF FATHER *Don't Know*

11 BIRTHPLACE OF FATHER (State or country) *Don't Know*

12 MAIDEN NAME OF MOTHER *Don't Know*

13 BIRTHPLACE OF MOTHER (State or country) *Don't Know*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Jno Leibold (Son)*
(Address) *871 Hanover St*

15 MAY 28 1915 ROBERT . KRAUTER,
Filed 1915 Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *May 27, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 1, 1914* to *May 27, 1915*, that I saw her alive on *May 27, 1915*, and that death occurred, on the date stated above, at *2:30 p.m.* The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Contributory *Exhaustion*
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) *J. C. Leary* M. D.
527, 1915 (Address) *1230 S. B. Chapin*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Mt. Olivet Cemetery* DATE OF BURIAL *May 29, 1915*

20 UNDERTAKER *Mrs. John H. Pfeiffer* ADDRESS *801 W. Fayette St.*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85612

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 C85612

1 PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 1917 Christian St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 12.)

2-FULL NAME

Elizbeth L. Friedel

(Residence in Baltimore: No. 1917 Christian St. 19 yrs. 9 mos. ds.)

St. 19 yrs. 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH August 6th 1895 (Month) (Day) (Year)

7-AGE 19 yrs. 9 mos. ds. or If LESS than 1 day, hrs. min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Operator Shirt Factory

9-BIRTHPLACE (State or country) Baltimore

PARENTS 10-NAME OF FATHER John Friedel 11-BIRTHPLACE OF FATHER (State or country) Germany 12-MAIDEN NAME OF MOTHER Mary Blumberg 13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Miss Margaret Friedel (Address) 1917 Christian St

15- MAY 28 1915 ROBERT KRAUTER, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 5-26-1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 18, 1915, to April 26, 1915, that I saw her alive on April 25, 1915, and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Contributory (SECONDARY) Hæthemic (Duration) 2 yrs. mos. ds.

(Signed) John C. Rozmus, M.D. 5-27-1915. [Address] 1302 W. Monument St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL London Park Cemetery May 29, 1915

20-UNDERTAKER ADDRESS Knell & Son 1729 W Pratt St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85613

CERTIFICATE OF DEATH

109

1-PLACE OF DEATH

U. S. Marine Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No

U. S. Marine Hospital

WARD

2-FULL NAME

Cornelius Nutt

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)

(Residence in Baltimore: No.

U. S. Marine Hospital

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Unknown

1880

7-AGE

35

If LESS than

1 day, hrs.,

or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Seaman

9-BIRTHPLACE

(State or country)

Virginia

10-NAME OF FATHER

Not known

11-BIRTHPLACE OF FATHER

(State or country)

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or country)

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Hospital record

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 26, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

May 26, 1915 to May 26, 1915

that I saw him alive on May 26, 1915

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstructions Ac
(Intussusception - small bowel
from caecal valve)

(Duration)

yrs

mos.

3 hrs

Contributory

(SECONDARY)

(Duration)

yrs

mos.

ds.

(Signed),

Chas. M. Vogel

M. D.

, 191

[Address]

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. 3 mos. In the ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mary's Cemetery

May 28, 1915

REGISTRAR

ADDRESS

St. Anthony's St. P. Rd.

15-MAY 28 1915 ROBERT . KRAUTER,

Filed, 191

Burial permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85644

42085644

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2116 N. Pratt St.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Fredericka Keuler (Keuler)

(Residence in Baltimore: No.

2116 N. Pratt

St. 28 yrs., 2 mos., 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

widowed

6-DATE OF BIRTH

March 17, 1849

(Month)

(Day)

(Year)

7-AGE

66 yrs., 2 mos., 9 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Jno. E. Keuler

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Fredericka Ellerman

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jacob Keuler

(Address)

2222 Fred. Ave.

15-

MAY 28 1915

ROBERT KRAUTER

Mortual Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 26, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 12 1914, to May 26 1915

that I saw him alive on May 26 1915

and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Toxaemia

Metastatic inflammation of appendix

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Carcinoma of uterus

(Duration) yrs. mos. ds.

(Signed)

Harold Kelly

M. D.

May 27, 1915 (Address) 2027 N. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Linden Park Cemetery

May 28, 1915

20-UNDERTAKER

ADDRESS

J.B. Hapgood 2238 Fred. Ave.

CAUSE OF DEATH is plain term, so that it may be properly classified. List statement of physician is not important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85645

CERTIFICATE OF DEATH.

50

C85645

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1407 E. Fayette*)ST. *5*

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

*Hannah R. Patz (Patz)*Residence in Baltimore: No. *1407 E. Fayette*St. *24* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH.

May

(Month)

(Day)

(Year) *1847*

7-AGE.

68

yrs.

mos.

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,

(State or Country), *Russia*10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER,

(State or Country), *Russia*12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER,

(State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Leurs*(Address) *1419 E. Baltimore*

15-

MAY 28 1915

ROBERT J. KRAUTER,

Filed..... 191... *MAY 28 1915*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5

(Month)

28

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*March 10th 1915, to May 27th 1915,*that I saw her alive on *May 27th 1915,*and that death occurred, on the date stated above, at *6:30 a.m.*

The CAUSE OF DEATH* was as follows:

Diabetic Mellitus(Duration) *18* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Diabetic Coma & Nausea(Duration) *1* mos. *15* ds.(Signed) *Edward J. Dillman* M. D.*May 28, 1915. (Address) 205 E. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Heaven Herring**2/28, 1915*

20-UNDERTAKER

ADDRESS

*Jack Leurs**1419 E. Baltimore*

COPIES OF DEATH IN plain terms, so that it may be properly entered in the records of the health department, are important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85647

CERTIFICATE OF DEATH

151 C85647
REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

1507 N. Stricker

ST. 15

WARD)

FULL NAME

Amelia L. Whittington

(Residence in Baltimore: No.

1507 N. Stricker St.

St.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE white 5-SINGLE, ~~Married~~ Single

6-DATE OF BIRTH May 27, 1915 (Month) (Day) (Year)

7-AGE If LESS than 1 day, 1/3 hrs. yrs. mos. ds. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

None.

BIRTHPLACE

(State or country)

Baltimore

PARENTS

10-NAME OF FATHER

Raymond L. Whittington

11-BIRTHPLACE OF FATHER

Md

12-MAIDEN NAME OF MOTHER

Amelia L. Orman

13-BIRTHPLACE OF MOTHER

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Sophy Orman

(Address)

1525 N. Stricker

15.

MAY 28 1915

ROBERT KRAUTER,

BURIAL PERMIT OFFICER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 27, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1915, to May 27, 1915,

that I saw her alive on May 27, 1915,

and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Congenital debility

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Geo. T. Kemp

M. D.

May 28, 1915 (Address) 8 W 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

May 28, 1915

20-UNDERTAKER

Samuel E. Taylor

ADDRESS

916

C85648

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

130

C85648

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Mercy Hospital

ST.:

12

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Marie Todd

(Residence in Baltimore: No.

1715 Maryland Ave

St.:

yrs.,

mos.,

da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single

6-DATE OF BIRTH,

Sept 4, 1895

(Month)

(Day)

(Year)

7-AGE,

19 yrs. 8 mos. 19 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

General

9-BIRTHPLACE,

(State or Country),

Va

10-NAME OF FATHER,

Saml. Armstrong

11-BIRTHPLACE OF FATHER

(State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Sallie Roberts

13-BIRTHPLACE OF MOTHER

(State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mercy Hospital

(Address)

Calvert St

15-

MAY 28 1915

ROBERT

KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 27, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 18, 1915, to May 27, 1915

that I saw her alive on May 27, 1915

and that death occurred, on the date stated above, at 7:00 P. M.

The CAUSE OF DEATH* was as follows:

Pelvic Abscess
General Infection
Duration 10 yrs. 8 mos. 19 ds.

CONTRIBUTORY (Secondary)

General Peritonitis
Duration about 8 ds.
(Signed) Edward J. Smith M. D.
May 28, 1915 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 9 mos. 9 ds. In the State yrs. 8 mos. 19 ds.

Where was disease contracted, if not at place of death? 1715 Maryland Ave

Former or usual residence 1715 Maryland Ave

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Richmond Va

May 28 1915

20-UNDERTAKER

ADDRESS

John H. Toadum 143 W. 11th St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 2011 Druidhill avenue, St. 14 WARD)

FULL NAME Robert A. Feaker,

(Residence in Baltimore: No. 2011 Druidhill avenue,

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, Married, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, September 29th, 1884. (Month) (Day) (Year)

7-AGE, 30 yrs., 7 mos., 28 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Public waiter, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Joseph T. Peaker,

11-BIRTHPLACE OF FATHER, (State or Country), Maryland,

12-MAIDEN NAME OF MOTHER, Lottie Jackson,

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas J. Peaker, brother,

(Address) 1409 Druidhill avenue.

15- MAY 28 1915 ROBERT KRAUTER, Serial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 27th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frederick H. Humpal, M. D. (Coroner.)

May 27th 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, May 30, 1915.

20-UNDERTAKER, John A. Bishop, ADDRESS 1107

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85650 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 C85650

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

2324 Reisterstown Rd 15

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Esch, Leth.

(Residence in Baltimore: No.

2324 Reisterstown Rd St. 40

yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6-DATE OF BIRTH

March 9, 1868

7-AGE

47 yrs. 1 mos. 18 ds. or less than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant Tailor

9-BIRTHPLACE (State or country)

Germany

PARENTS

10-NAME OF FATHER

Not known

11-BIRTHPLACE OF FATHER (State or country)

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or country)

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Amie J. Leth.

(Address)

2324 Reisterstown Rd.

15-MAY 28 1915

ROBERT KRAUTER,

Filed, 191

Official Death Record

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 27, 1915

17-I HEREBY CERTIFY, That I attended deceased from

May 26, 1915, to May 27, 1915.

that I saw him alive on May 27, 1915.

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Contributory (SECONDARY)

Exhaustion

(Signed)

Chas. H. Bunker, M. D.

May 28, 1915 (Address) 1100 E. L. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Green Ridge Cemetery

DATE OF BURIAL

May 30, 1915

20-UNDERTAKER

Wm. Houston

ADDRESS

230 N. Green

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 8 WARD)

REGISTERED NO. C

FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH.

August 21st, 1860
(Month) (Day) (Year)

7-AGE,

54 yrs. 9 mos. 5 ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,

(State or Country),

Baltimore Md

10-NAME OF FATHER,

Thomas E Burton

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Hallen Hatten

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph M. Foster

(Address)

1542 N. Wolfe St

15-

MAY 29 1915

Filed

191

HARRY O. ANDREWS,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 26, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov. 13, 1914, to May 26, 1915,

that I saw him alive on May 23, 1915,

and that death occurred, on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 15 mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) 15 minutes

(Signed) George A. Shattman, M. D.

May 27, 1915 (Address) 1126 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

May 29th, 1915.

20-UNDERTAKER

George Schilling Sons

ADDRESS

1126 E Monument St

important. See instructions on back of certificate.

C85652

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85652

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Runnery Lane* *Baltimore* St.; *25* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

July 10th, *1856*
(Month) (Day) (Year)

7-AGE,

58 yrs., *10* mos., *17* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Frame Nurse

9-BIRTHPLACE,

(State or Country),

England

10-NAME OF FATHER,

William Bell

11-BIRTHPLACE OF FATHER

(State or Country),

England

12-MAIDEN NAME OF MOTHER

Ellen Mc Boury

13-BIRTHPLACE OF MOTHER

(State or Country),

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Ann J. Hill*(Address) *Catonsville*

15-

MAY 29 1915

HARRY O. ANDREWS,

REG. 1915

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May, *27th*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 20, *1915*, to *May 27*, *1915*,that I saw him alive on *May 27*, *1915*,and that death occurred, on the date stated above, at *10:35* a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) *1* yrs., *—* mos., *—* ds.

CONTRIBUTORY (Secondary)

General Hemorrhage(Duration) *7* yrs., *—* mos., *—* ds.(Signed) *B. H. Gustafson* M. D.*May 27*, *1915*. (Address) *University Hospital*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *7* yrs., *—* mos., *—* ds. In the *25* yrs., *—* mos., *—* ds.Where was disease contracted, if not at place of death? *Baltimore*Former or usual residence *Runnery Lane Baltimore*

19-PLACE OF BURIAL OR REMOVAL,

Mount Olivet

DATE OF BURIAL,

May 29, *1915*

20-UNDERTAKER

E. M. Mitchell 1800 12th St. N. W. D.C.

ADDRESS

C85653

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

ST.:

WARD:

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MAY 29 1915

Filed....., 191..

HARRY O. ANDREWS,

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

aug 1 1915, to May 27 1915, that I saw h^r alive on May 26 1915, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration).....yrs. 10. mos. da.

CONTRIBUTORY (Secondary)

(Duration).....yrs. 3. mos. da.

(Signed).....M. D.

May 28, 1915 (Address) 839 S. Elmwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs. mos. da. In the State.....yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

C85654

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 C85654

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 W. Mather St. ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 138 W. Mather St. St.; 3 yrs. 3 mos. 3 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Married
(Write the word.)

6-DATE OF BIRTH

Dec 22, 1874
(Month) (Day) (Year)

7-AGE

40 5 6
yrs. mos. da.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.
(State or Country),

Md.

10-NAME OF FATHER,

J. K. Nelson

11-BIRTHPLACE OF FATHER
(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Mary Street

13-BIRTHPLACE OF MOTHER
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ira S. Meyer
(Address) 138 W. Mather St.

15-

MAY 29 1915

HARRY O. ANDREWS,

Filed

191

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 28, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug - 1914, to May 28 1915, that I saw her alive on May 27 1915, and that death occurred, on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

Epithelioma Eye
with metastasis to breast
and abdomen (Operation, Micro-
scopic Exam. 1 Day (Duration) 2 yrs. 5 mos. da.CONTRIBUTORY
(Secondary)(Signed) Geo. Strauss, M. D.
May 28 1915 (Address) 1935 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Laurel Md.

DATE OF BURIAL

May 31 1915

20-UNDERTAKER

C. A. Kutzatock 2433 W. North Ave.

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85055

CERTIFICATE OF DEATH.

28 C85055

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2021 Clifton Ave ST.: 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2021 Clifton Ave St.: 19 yrs., 9 mos., 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH.

August 3, 1895
(Month) (Day) (Year)

7-AGE,

19 yrs., 9 mos., 24 ds.

IF LESS than 1 day.

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).None

9-BIRTHPLACE, (State or Country).

Baltimore Md

10-NAME OF FATHER,

John Trautwein

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Caroline Abdofer

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Trautwein(Address) 2021 Clifton Ave

15-

MAY 29 1915

ROBERT J. KRAUTER,
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 27, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

February 1915, to May 27 1915,that I saw he alive on May 13 1915,and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 1 yrs., 3 mos., — ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs., — mos., — ds.(Signed) Chas. Hoffman M. D.May 28, 1915 (Address) 210 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death — yrs., — mos., — ds. In the — State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cem.

DATE OF BURIAL,

May 30 1915

20-UNDERTAKER

Narry W. Ehlen

ADDRESS

1944 W. North Ave

CASE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85056

50

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1023 N. Caroline

ST.:

7

WARD)

REGISTERED No. C

2-FULL NAME

Frank A. Finkle

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1023 N. Caroline

St.: 38 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

October

7th

1883

(Month)

(Day)

(Year)

7-AGE.

61

7

20

If LESS than 1 day.

yrs.

mos.

da.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Vice President of

(b) General nature of industry, business, or establishment in which employed (or employer).

N. M. Koch Impaling

9-BIRTHPLACE,

(State or Country).

Germany

10-NAME OF FATHER.

Ferdinand Finkle

11-BIRTHPLACE OF FATHER

(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Theresa Beckman

13-BIRTHPLACE OF MOTHER

(State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie H. Finkle

(Address) 1023 N. Caroline St.

15-

MAY 29 1915 ROBERT J. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 27th, 1915.

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

May 27th, 1915.and that death occurred, on the date stated above, at 2nd P. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

Hypertension

(Signed) Robert A. Meyer, M. D.

May 28th, 1915 (Address) 1031 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Most Holy Redeemer Church

DATE OF BURIAL.

May 31, 1915.

20-UNDERTAKER

Henry Block Son

ADDRESS

1301 E. Eager St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85657

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 C85657

PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

Little Sisters of the Poor

ST. 10 WARD

John Fairby (Rainey)
Lit. Sisters Poor

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and add out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH Mass 1890 (Month) (Day) (Year)

7-AGE 95 yrs. mos. ds. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Germantown Pa.

10-NAME OF FATHER John Fairby 11-BIRTHPLACE OF FATHER (State or country) Unknown 12-MAIDEN NAME OF MOTHER Ellen Branlon 13-BIRTHPLACE OF MOTHER (State or country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15- MAY 29 1915 ROBERT KRAUTER, Serial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 5/29 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 21, 1915, to May 29, 1915, that I saw him alive on May 28, 1915, and that death occurred, on the date stated above, at 91 m. The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. ds. 3

Contributory (SECONDARY) Old age

(Duration) yrs. mos. ds.

(Signed) C. H. Hayman M. D. 5/29 1915 [Address] 838 E. Preston

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 12 yrs. 3 mos. 3 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL London Park May 31 1915

20-UNDERTAKER ADDRESS Geo W Little 531 E. Frederick

N. B.—Every item of information supplied on this form is subject to inspection. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85653

CERTIFICATE OF DEATH

x 91

C85653

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No.)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from
May 24, 1915, to May 26, 1915,

that I saw him alive on May 26, 1915,
and that death occurred, on the date stated above, at 9:40 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Contributory
(SECONDARY)

(Signed)

May 26, 1915 (Address)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MAY 29 1915

ROBERT E. ERAUTER

JOHNS HOPKINS HOSPITAL

MAY 27 1915

Filed, 191

Burial Permit

UNDERTAKER

ADDRESS

FOR ANATOMICAL PURPOSES

N.B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 500 W. Hoffman st.

ST. 17

WARD)

2-FULL NAME

Ida D. Winters,

(Residence in Baltimore: No. 500 W. Hoffman st.

REGISTERED No. C:

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female,

4-COLOR OR RACE,

Colored,

5-SINGLE,

MARRIED, Single,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 10th, 1914.
(Month) (Day) (Year)

7-AGE,

0 yrs. 10 mos. 17 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None,

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

Baltimore, Md.

10-NAME OF FATHER,

William C. Winters,

11-BIRTHPLACE OF FATHER

(State or Country).

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

May Jones,

13-BIRTHPLACE OF MOTHER

(State or Country).

Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Jones.

(Address) 500 W. Hoffman st.

15-

MAY 29 1915 ROBERT KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 27th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, au-

topsy or inquiry.) And that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Thompson, M. D. (Coroner.)

May 28, 1915. (Address) 3310 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mont Auburn May 29 1915

20-UNDERTAKER

ADDRESS

Walter Owens 235 E. 1st St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85630

70
70 C85630
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1811 Eussor St. ST. 9 WARD)

2-FULL NAME John E Schmidt

(Residence in Baltimore: No. 1811 Eussor St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6-DATE OF BIRTH April 29, 1909
(Month) (Day) (Year)

7-AGE 6 yrs. 28 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION None
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Ind -

10-NAME OF FATHER Edward L. Schmidt

11-BIRTHPLACE OF FATHER (State or country) Ind -

12-MAIDEN NAME OF MOTHER Catherine Reese

13-BIRTHPLACE OF MOTHER (State or country) Ind -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward L. Schmidt

(Address) 1811 Eussor St.

MAY 29 1915

ROBERT J. KRAUTER,

Filed

191

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 27, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 27, 1915 to May 27, 1915, that I saw him alive on May 27, 1915, and that death occurred, on the date stated above, at 5:20 a.m. The CAUSE OF DEATH* was as follows:
Coronary

Contributory (SECONDARY) Unknown (Duration) about 1 hour yrs. mos. ds.
(Signed) Harry J. Brady M. D. May 28, 1915 (Address) 1024 E. Annapolis

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Valley Redemptive Church May 29, 1915

20-UNDERTAKER ADDRESS

George J. Reuth 1735 Harford Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 School ST. 15 WARD)2-FULL NAME Mary E. McCormick(Residence in Baltimore: No. 1512 School St. 47 yrs., — mos. 20 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <u>Female</u>	4-COLOR OR RACE <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Married</u>
6-DATE OF BIRTH, <u>May 3rd</u> , 1868 (Month) (Day) (Year)		
7-AGE, <u>47</u> yrs., <u>—</u> mos., <u>20</u> ds.		If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work... <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)...		

9-BIRTHPLACE, (State or Country), <u>Baltimore</u>
10-NAME OF FATHER, <u>Patrick M. McCormick</u>
11-BIRTHPLACE OF FATHER (State or Country), <u>Ireland</u>
12-MAIDEN NAME OF MOTHER, <u>Catherine Tierney</u>
13-BIRTHPLACE OF MOTHER (State or Country), <u>Ireland</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John F. McCormick
(Address) 1512 School St.

15-MAY 29 1915 ROBERT KRAUTER, Registrar.
Filed May 29 1915 Serial Permit 10

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 28th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 23rd 1915, to May 27th 1915, that I saw her alive on May 27th 1915, and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) 2 yrs., — mos., — ds.
CONTRIBUTORY (Secondary) Atrophic Croup
of the Lungs (Duration) 6 yrs., — mos., — ds.
(Signed) J. M. J. Sullivan M. D.
May 28th, 1915. (Address) 17 R. I. N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, <u>New Cathedral</u>	DATE OF BURIAL, <u>May 31</u> , 1915
20-UNDERTAKER, <u>Wm Cook</u>	ADDRESS, <u>5022 North</u>

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085002

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

085002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.: *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Rose Warner(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs., *2* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Single*

6-DATE OF BIRTH,

March 6th, 1915.
(Month) (Day) (Year)

7-AGE,

2 mos. 21 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

*MAY 29 1915**ROBERT KRAUTER*

Filed

*191**Burial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 27th, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 1st* 1915, to *May 27th* 1915, that I saw her alive on *May 26th* 1915, and that death occurred, on the date stated above, at *6:00 a.m.*

The CAUSE OF DEATH* was as follows:

Malnutrition & Mal-assimilation(Duration) yrs. *1* mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Elmer G. Hall* M. D.*May 27, 1915.* (Address) *1617 E. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. ds. In the State yrs. *2* mos. *21* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*Cathedral**May 29, 1915*

20-UNDERTAKER

ADDRESS

M. Faherty & Sons 606 Lafayette St.

CAUSE OF DEATH in plain terms, so that it may be properly translated. Exact statement of cause of death is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

085623

CERTIFICATE OF DEATH.

91 085623
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.: *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs. *9* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)

6-DATE OF BIRTH, *June 29th, 1914*
(Month) (Day) (Year)

7-AGE, *10 yrs., 26 mos., 26 ds.* If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER, *Charles S. Tewell*

11-BIRTHPLACE OF FATHER (State or Country), *W Va*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1421 Division St*

15-

Filed *MAY 29 1915*

ROBERT KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 25, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1st 1915, to *May 25th* 1915,
that I saw him alive on *May 25th* 1915,
and that death occurred, on the date stated above, at *11:15 P. m.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. ds. *4*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. *1*

(Signed) *Oliver H. Hall* M. D.
May 27, 1915 (Address) *16178 North Ave.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *9* mos. ds. In the State yrs. *12* mos. *26* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral May 29, 1915

20-UNDERTAKER

ADDRESS

W. H. A. Sons 606 Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85634

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2040 Hollis St.* ST.; *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2040 Hollis St.* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)6-DATE OF BIRTH, *Nov. 5, 1914*
(Month) (Day) (Year)7-AGE, *6 yrs. 4 mos. 2 ds.* If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Beth. City*10-NAME OF FATHER, *Bernard A. Frank*11-BIRTHPLACE OF FATHER (State or Country), *Beth. Md.*12-MAIDEN NAME OF MOTHER *Helen B. Crump*13-BIRTHPLACE OF MOTHER (State or Country), *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *B. A. Frank*(Address) *2040 Hollis St.*15-MAY 29 1915
FiledROBERT KRAUTER,
Marial Permit Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 29, 1915*
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *May 22 1915* to *May 27 1915*, that I saw him alive on *May 28, 1915*, and that death occurred, on the date stated above, at *8 A. M.*

The CAUSE OF DEATH* was as follows:

Pneumonia & left lung
(Duration) yrs. mos. ds.CONTRIBUTORY (Secondary) *Whooping Cough*(Signed) *J. M. Wilson* M. D.
May 29, 1915 (Address) *1735 Hollis St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

New Cathedral *May 31, 1915*

20-UNDERTAKER ADDRESS

M. S. Frank *1921 N. Poth St.*

CAUSE OF DEATH in plain terms, so that it may be properly entered. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2628 Boone*)

2-FULL NAME *Amanda Holmes*

(Residence in Baltimore: No. *2628 Boone*)

REGISTERED NO. C

ST.: *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow* (Write the word.)

6-DATE OF BIRTH, *Unknown*, *1* (Month) (Day) (Year)

7-AGE, *9.0* yrs., mos., ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *None* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *VA*

PARENTS. 10-NAME OF FATHER, *Unknown* 11-BIRTHPLACE OF FATHER (State or Country), *Unknown* 12-MAIDEN NAME OF MOTHER, *Unknown* 13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Holmes* (Address) *2628 Boone*

15- *ROBERT A. KRANTZ*, Registrar. Filed *MAY 20 1915*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 28*, *1915*. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) find that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes

(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary) *Senility*

(Duration) yrs., mos., ds.

(Signed) *Edmund J. Russell* M. D. (Coroner.)

May 28, 1915 (Address) *425 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death...yrs....mos....ds. State...yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Auburn* DATE OF BURIAL, *May 30, 1915*

20-UNDERTAKER *James H. Deems* ADDRESS *1303 Ruston*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85666

119 C85666

PLACE OF DEATH
CITY OF BALTIMORE: (No. 1614 Light ST. 23 WARD)
2-FULL NAME Mary E. Greal
(Residence in Baltimore: No. 1614 Light St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

1-SEX Female 4-COLOR OR RACE White 5-SINGLE Widow
MARRIED WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH Nov 23, 1866
(Month) (Day) (Year)
7-AGE 48 yrs. 6 mos. 4 ds. or ML? If LESS than 1 day, hrs.
8-OCCUPATION (a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore
PARENTS
10-NAME OF FATHER John Quark
11-BIRTHPLACE OF FATHER (State or country) Maryland
12-MAIDEN NAME OF MOTHER Josephine Lambert
13-BIRTHPLACE OF MOTHER (State or country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruth Crispens
(Address) 1614 Light St

15- MAY 29 1915 ROBERT J. KRAUTER,
Filed 191 Serial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 27, 1915
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I attended deceased from May 1st, 1915, to, May 27, 1915,
that I saw her alive on May 26, 1915,
and that death occurred, on the date stated above, at 1 A. m.
The CAUSE OF DEATH* was as follows:

Themic coma
Contributory (SECONDARY) Acute Nephritis (Duration) yrs. mos. ds. 5
(Signed) J. F. Hawkings (Duration) yrs. mos. ds. 30
May 29, 1915 [Address] 1614 Light St
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL bedas Hill Cem DATE OF BURIAL 7 29 1915
20-UNDERTAKER J. F. Hawkings ADDRESS 39 E. Fort

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

2-FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

St.;

yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed

191

Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

January 15 1915 to May 27 1915

that I saw her alive on May 27 1915

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Rupture of thoracic aorta

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) 10 yrs. mos. ds.

(Signed)

May 27, 1915 (Address) 823 N. Patterson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oak Hill Cem.

May 29, 1915

20-UNDERTAKER

ADDRESS

Geo M. Fink

811 N. Wolfe

CASE OF DEATH in print form, so that it may be properly classified. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. *1401 Park Ave.* St. *14* WARD)

2-FULL NAME *Ada Marie Senegre. (Devegre)*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No. *1401 Park Ave.* St. *17* yrs. *7* mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*

4-COLOR OR RACE *White*

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) *Widowed*

6-DATE OF BIRTH

October 24th 1844
(Month) (Day) (Year)

7-AGE

70 yrs. *7* mos. *5* ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

New Orleans, La.

10-NAME OF FATHER

Leri Peirce

11-BIRTHPLACE OF FATHER
(State or country)

Boston, Mass.

12-MAIDEN NAME OF MOTHER

Emmentine Keyl

13-BIRTHPLACE OF MOTHER
(State or country)

Philadelphia, Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. Martin Burns, U.S.

(Address)

1401 Park Ave., Balt. Md.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 29th 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

May 10th 1915, to, *May 28th 1915*,

that I saw her alive on *May 28th 1915*,

and that death occurred, on the date stated above, at *245 A. M.*

The CAUSE OF DEATH* was as follows:

Senile arterio-sclerosis

Contributory
(SECONDARY)

(Duration) *10* yrs. *7* mos. *5* ds.

Renal insufficiency

(Duration) *29* days

(Signed)

Edw. W. Van Noy M. D.
May 29th 1915 [Address] *202 W. Lafayette Ave.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

New Orleans, La.

DATE OF BURIAL

May 29th 1915

20-UNDERTAKER

Henry W. Featherston Co.

ADDRESS

1111 North Howard

15-

MAY 29 1915

ROBERT KRAUTER

Filed

191

Marial Permit Clerk

REGISTRAR

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85669

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 C85669

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str. yrs. 15 mos. (ls.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word) Single

6 DATE OF BIRTH Feb 11, 1914 (Month) (Day) (Year)

7 AGE 1 yrs. 3 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Balto Md

10 NAME OF FATHER Ester Bobbitt

11 BIRTHPLACE OF FATHER (State or country) Raleigh, N.C.

12 MAIDEN NAME OF MOTHER Martha Jenkins

13 BIRTHPLACE OF MOTHER (State or country) Orange Co Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Esther Bobbitt

(Address) 402-22 1/2 Street

15 MAY 29 1915 ROBERT J. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 27, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 22nd May, 1915, to 27th 1915, that I saw her alive on May 27, 1915, and that death occurred, on the date stated above, at 8 P. m. The CAUSE OF DEATH* was as follows:

Broncho Pneumonia Left side (Duration) yrs. mos. 7 ds

Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) C. S. Gabriel M. D. May 28, 1915 (Address) 2413 St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Laurel Cemetery May 29, 1915 ADDRESS 517 Robert St. Undertaker Geo. W. Holland

Nathia E. Monroe
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 34)

WARD)

2-FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1N.)

(Residence in Baltimore: No. 3704 Reisterstown Road, St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).10-NAME OF
FATHER11-BIRTHPLACE
OF FATHER
(State or Country)12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

ROBERT J. KRAUTER,

Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

May 24, 1915, to May 29, 1915,

that I saw her alive on May 29, 1915,

and that death occurred, on the date stated above, at 1:35 a.m.

The CAUSE OF DEATH* was as follows:

Subacute renal disease, accompanied by general debility.

(Duration) yrs. mos. ds.

CONTRIBUTORS
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence 3704 Reisterstown Rd.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Newark, N.J.

May 29, 1915

20-UNDERTAKER

ADDRESS

N. J. Dickner Sons

North Pa.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *920 S. East Ave.* St. *1* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME

(Residence in Baltimore: No. *920 S. East Ave.* St. *6* yrs. *6* mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

white

5-SINGLE,

*MARRIED, Widower**OR DIVORCED,**(Write the word.)*

6-DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7-AGE

*adult**86* yrs. *5* mos. *5* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Foley*(Address) *920 S. East Ave.*

15-

Filed

MAY 29 1915

ROBERT

KRAUTER

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 28, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 23, 1915, to May 28, 1915,*that I saw him alive on *May 28, 1915,*and that death occurred, on the date stated above, at *1:30 P. m.*

The CAUSE OF DEATH* was as follows:

Facial Erysipelas

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

Toxic Nephritis(Signed) *M. J. McCarry* M. D.*May 29, 1915* (Address) *839 S. Ellwood*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Severell Md

DATE OF BURIAL

May 29, 1915

20-UNDERTAKER

W. Dickman

ADDRESS

1014 R

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* 7 WARD)

2-FULL NAME

(Residence in Baltimore: No. *916 N. Broadway* St. *70* yrs., *10* mos., *10* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH.

May 1892
(Month) (Day) (Year)

7-AGE,

23

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Lady Clerk

9-BIRTHPLACE,

(State or Country),

N. Y.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Lewis*(Address) *1419 E. Baltimore*

15-

MAY 29 1915

Filed

191

ROBERT KRAUTH

Marital Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 29, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*May 28, 1915, to May 29, 1915*that I saw her alive on *May 29, 1915*and that death occurred, on the date stated above, at *4:20 p.m.*

The CAUSE OF DEATH* was as follows:

*Acute Malarial Infection**about*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Septic Meningitis

(Duration) yrs. mos. ds.

(Signed) *Edward J. Smith D.**May 29, 1915* (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *916 N. Broadway*Former or usual residence *916 N. Broadway*

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Warburg Rd

DATE OF BURIAL,

3/30, 1915

ADDRESS

1419 E. Baltimore

20-UNDERTAKER

Jack Lewis

CASE OF DEATH IN PAIR FORM, so that it may be properly completed. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.; *8* WARD)2-FULL NAME *Elaine Kitzmeyer*Residence in Baltimore: No. *Balto Cemetery Gate* St.; yrs. mos. ds.)151
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *May 28, 1915*
(Month) (Day) (Year)7-AGE, If LESS than 1 day, *12 1/2 hrs. or min.?*
yrs. mos. ds.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) *Balto. Maryland*10-NAME OF FATHER, *Milton S. Kitzmeyer*11-BIRTHPLACE OF FATHER (State or Country), *Balto. Md.*12-MAIDEN NAME OF MOTHER *Inogene Holmabee*13-BIRTHPLACE OF MOTHER (State or Country), *Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Milton S. Kitzmeyer*(Address) *East North Ave. Extension*

15-

MAY 29 1915

ROBERT A. KRAUTER,
Municipal Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 29, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 28, 1915*, to *May 29, 1915*, that I saw her alive on *May 29, 1915*, and that death occurred, on the date stated above, at *11:20 Am.*

The CAUSE OF DEATH* was as follows:

Respiratory distress
(6 1/2 months)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *H. H. Warner* M. D.
May 29, 1915 (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery*DATE OF BURIAL, *May 29, 1915*20-UNDERTAKER *Henry W. Means & Son*ADDRESS *805 N. Calver St.*

CARE OF DEATH IN THIS STATE, TO BE FURNISHED BY THE HEALTH DEPARTMENT, CITY OF BALTIMORE, IS IMPORTANT. See instructions on back of certificate.

C85674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85674

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 E. North Av. ST. 17 WARD)

2-FULL NAME

(Residence in Baltimore: No. 307-E North Av. St.; yrs., mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIEDMarriedWIDOWEDOR DIVORCED,(Write the word.)

6-DATE OF BIRTH,

April 28, 1838
(Month) (Day) (Year)

7-AGE,

77 yrs. 1 mos. 1 da.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

Newspaper Man

9-BIRTHPLACE,

(State or Country),

Hagerstown Md.

10-NAME OF FATHER,

not known

11-BIRTHPLACE OF FATHER

(State or Country),

not known

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER

(State or Country),

not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rachael M. Davis(Address) 307-E North Av.

15-

MAY 29 1915

ROBERT . KRAUTER,

Mar. 1st. Permit. Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 29th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1914, to May 29th 1915,that I saw him alive on May 29, 1915,and that death occurred, on the date stated above, at 5:45 A.M. in.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

.....

..... (Duration) 10 yrs. mos. da.

CONTRIBUTORY (Secondary)

Cerebral Thrombosis..... (Duration) 7 yrs. mos. da.(Signed) Gustav C. Bohme M. D.May 29, 1915. (Address) 3014 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. da. In the State..... yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery

DATE OF BURIAL,

May 31st, 1915.20-UNDERTAKER Newark Mowen Co

ADDRESS

108 W North Av

CARE OF DEATH IN PAINT TERMS, so that it may be properly examined. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

41 C85676

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

Str.; 48 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Black 5-STATUS MARRIED Married

6-DATE OF BIRTH Unknown; 1 (Month) (Day) (Year)

7-AGE 53 - yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Coachman (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Howard Co Md

PARENTS 10-NAME OF FATHER William Joyce 11-BIRTHPLACE OF FATHER (State or country) Howard Co Md 12-MAIDEN NAME OF MOTHER Malinda Bushin 13-BIRTHPLACE OF MOTHER (State or country) Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 MAY 29 1915 Filed 1915 ROBERT KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 28, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26, 1915, to May 27, 1915, that I saw him alive on May 27, 1915, and that death occurred, on the date stated above, at 5:30 A.M. The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum (Clinical Diagnosis) about 1 yr. mos. ds. Contributory Labor Pneumonia (SECONDARY) (Duration) yrs. mos. 6 ds.

(Signed) Edwin K. Ballard M.D. May 28, 1915 (Address) 1622 Mt Royal Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cathedral Cemetery DATE OF BURIAL May 31, 1915 20-UNDERTAKER Felix B. Pye, 102 E. Mulberry St ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85677

CERTIFICATE OF DEATH

56 C85677
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 520 Columbia

ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

~~Harriette~~ Sinclair

(Residence in Baltimore: No. 520 Columbia Ave

St.: yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6-DATE OF BIRTH

Aug 15, 1868 (Month) (Day) (Year)

7-AGE

46 yrs. 9 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Birkenhead England

10-NAME OF FATHER

Steven Moor

11-BIRTHPLACE OF FATHER (State or country)

England

12-MAIDEN NAME OF MOTHER

Nettie May

13-BIRTHPLACE OF MOTHER (State or country)

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bora Mazens

(Address)

520 Columbia Ave

MAY 29 1915

ROBERT . KRAUTER,

Serial Permit Clerk

Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 28, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from May 28, 1915, to May 28, 1915.

that I saw him alive on May 27, 1915, and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Uremia

Contributory (SECONDARY) alcoholism (Duration) yrs. 2 mos. ds.

(Signed) J. E. Poulton M. D. May 28, 1915 (Address) 615 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Back Lawn Cem. May 30, 1915

20-UNDERTAKER

Walter J. Turner 1842 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85678

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *825 Cator Ave* ST.; *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *William H. Wilbur*(Residence in Baltimore: No. *825 Cator Ave* St.; *2* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, *widower*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Jan *12*, *1833*
(Month) (Day) (Year)

7-AGE,

82 yrs., *4* mos., *17* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).*Merchant*
*Sailor*9-BIRTHPLACE,
(State or Country).*Troy N. Y.*10-NAME OF
FATHER*John Wilbur*11-BIRTHPLACE
OF FATHER
(State or Country).*N. Y.*12-MAIDEN NAME
OF MOTHER*Malvina Marks*13-BIRTHPLACE
OF MOTHER
(State or Country).*N. Y.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Oliver W. Van Doren

(Address)

825 Cator Ave

15-

MAY 29 1915 ROBERT . KRAUTER,
Filed... 191... *M. J. A. ...* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May *29*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Nov. *1915*, to *May 29* *1915*,
that I saw him alive on *May 128* *1915*,
and that death occurred, on the date stated above, at *3 a* m.
The CAUSE OF DEATH* was as follows:*Senility*
(Duration)..... yrs..... mos..... ds.
CONTRIBUTORY *Hæmorrhage from bladder* (Cause)
(Secondary).....
(Duration)..... yrs..... mos..... ds.
(Signed)..... *John Evans*..... M. D.
5-29, *1915* (Address)..... *502 ...**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
FERENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the..... yrs..... mos..... ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

North Adams Mich.

DATE OF BURIAL,

6/2, *1915*

20-UNDERTAKER

William Cork

ADDRESS

307-E North

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85679

CERTIFICATE OF DEATH.

7

C85679

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1110 N Bond

ST.: 8 WARD)

REGISTERED NO. C

2-FULL NAME

Mr H. Logue (Logue)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1110 N. Bond

St.; 1 yrs. 4 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

Infant

6-DATE OF BIRTH.

Jan 24, 1914

(Month)

(Day)

(Year)

7-AGE.

1 yr. 4 mos. 5 ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE, (State or Country),

Baltimore Md

PARENTS.

10-NAME OF FATHER,

Bernard J. Logue

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Laura V. Warner

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Laura V. Logue

(Address)

1110 N. Bond St.

15 MAY 30 1915

Filed

191

ROBERT KRAUTER,

Burial Permit Clerk.

Registrar.

2 P. M.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 29th, 1915,

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from May 26th 1915 to May 29th 1915, that I saw him alive on May 29th 1915, and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) 3 mos. 3 ds.

CONTRIBUTORY (Secondary)

Violent Convulsions
Signed: H. A. Meyer M. D.
May 29th 1915 (Address) 1031 N. Carroll St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Cathedral May 30, 1915

20-UNDERTAKER

ADDRESS

K. C. Niedefeld 914 Green St.

Every item on this form should be carefully filled out. Incomplete or incorrect information will result in the statement of OCCUPATION being classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85680

HEALTH DEPARTMENT--CITY OF BALTIMORE

64 C85680

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C.....

CITY OF BALTIMORE: (No.....

St.:.....

WARD).....

(If death occurred in a hospital or institution, give its NAME instead of street and number and RH out No. 18.)

2-FULL NAME

James Simpson

(Residence in Baltimore: No.....

653 W. Lexington St.

St.:.....

yrs.....

mos.....

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widower

6-DATE OF BIRTH

April 20 - 1845

7-AGE

70

If LESS than
1 day, hrs.,
..... yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9-BIRTHPLACE

(State or country)

Md

10-NAME OF FATHER

James Simpson

11-BIRTHPLACE OF FATHER

(State or country)

Md

12-MAIDEN NAME OF MOTHER

Don't Know

13-BIRTHPLACE OF MOTHER

(State or country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sister Benedict

(Address)

Little Sisters of the Poor

15-

MAY 30 1915

ROBERT . KRAUTER

Murial Permit Officer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 28

1915

17- I HEREBY CERTIFY, That I attended deceased from

May 27 1915

191

that I saw him alive on May 27 1915

191

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

1 day

(Duration)

yrs.....

mos.....

ds.....

Contributory (SECONDARY)

Coma

(Duration)

yrs.....

mos.....

ds.....

(Signed),

J. A. Warner

M. D.

May 28, 1915

[Address]

1133 Valley St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.....

mos.....

15 days in the

State

yrs.....

mos.....

ds.....

Where was disease contracted, if not at place of death?

Former or usual residence

653 W Lexington St

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross

May 31 1915

20-UNDERTAKER

ADDRESS

H. C. Wadfield 914 Greenmount Ave

C85682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 C85682

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *327. Furrow*ST.: *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *327 Furrow*St.: *50* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Married*

6-DATE OF BIRTH,

*Feb.**22.**1915*

(Month)

(Day)

(Year)

7-AGE,

*58.**3.**6.*

da.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Super

(b) General nature of industry, business, or establishment in which employed (or employer).

Storekeeper

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

M. K. Davis

11-BIRTHPLACE OF FATHER

(State or Country),

Id.

12-MAIDEN NAME OF MOTHER

Salie Swall

13-BIRTHPLACE OF MOTHER

(State or Country),

Id.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Louie B. Davis

(Address),

327 Furrow St

15-

MAY 30 1915 ROBERT . KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May**28.**1915*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

*May 22**1915*

to

*May 28.**1915.*

that I saw him alive on

*May 27.**1915.*and that death occurred, on the date stated above, at *5.30 a.m.*

The CAUSE OF DEATH* was as follows:

Inter cerebral Hemorrhage

(Duration)

yrs.

mos.

da.

CONTRIBUTORY (Secondary)

(Duration)

yrs.

mos.

da.

(Signed)

M. D.

*May 28.**1915*

(Address)

1735 Holborn St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

da.

In the

State

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

MAY 30 1915

20-UNDERTAKER

Geo A Gerbig

ADDRESS

Baltimore

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C85683

CERTIFICATE OF DEATH

170 C85683

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *2001 Frederick Ave.* ST. *20* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Julia P. Stolzenbach*

(Residence in Baltimore: No. *2001 Frederick Ave.* ST. *20* WARD)

Yrs. *Life* Mos. *Time* Ds. *Time*

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married* (Write the word)

6-DATE OF BIRTH *March 10, 1872* (Month) (Day) (Year)

7-AGE *43* yrs. *2* mos. *18* ds. or less than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

House Wife

9-BIRTHPLACE (State or country)

Baltimore Md.

PARENTS

10-NAME OF FATHER

Charles H. J. Meyer

11-BIRTHPLACE OF FATHER (State or country)

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Margaret J. Bayer

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Stolzenbach

(Address)

2001 Frederick Ave.

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *May 28, 1915* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *March 5th, 1915* to *May 28, 1915*.

that I saw her alive on *May 28, 1915*.

and that death occurred, on the date stated above, at *1 A* m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) *2* yrs. *8* mos. *8* ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

W. H. Braegle M. D.
(Address) *1328 S. Charles St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

MAY 31 1915

20-UNDERTAKER

ADDRESS

Geo. A. Lerby *Balt & Payne*

15-MAY 30 1915

ROBERT J. KRAUTER

Marial Permit Clerk

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *109 S. Catherine* ST.: *20* WARD)
2-FULL NAME *Frances Baumann*
(Residence in Baltimore: No. *109 S. Catherine* St.; *28* yrs. — mos. — ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and RW out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE MARRIED *Married* WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH *Aug 20 1863*
(Month) (Day) (Year)
7-AGE *51* yrs. *9* mos. *9* ds. or min.?
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) *Housework*

9-BIRTHPLACE (State or country) *W. Va*

PARENTS
10-NAME OF FATHER *Henry Spittle*
11-BIRTHPLACE OF FATHER (State or country) *W. Va*
12-MAIDEN NAME OF MOTHER *Mary Paine*
13-BIRTHPLACE OF MOTHER (State or country) *W. Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Geo Kaumann*

(Address) *109 S. Catherine*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 29 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Feb 1 1915*, to *May 29 1915*, that I saw *him* alive on *May 28 1915*, and that death occurred, on the date stated above, at *10:15 am*.

The CAUSE OF DEATH* was as follows:

Chlor Bright's Disease

Contributory (SECONDARY) *Arteriosclerosis*

(Signed) *H. H. Snyder* M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

When was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *London Park*

DATE OF BURIAL *May 31 1915*

20-UNDERTAKER *Wm Cook*

ADDRESS *502 E. North*

18- MAY 30 1915

ROBERT KRAUTER

MARIAL Permit Clerk

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

150 C85685

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *451 Grindall*)

ST. *24* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Lemuel Hodges*

(Residence in Baltimore: No. *451 Grindall*)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Richard A. Hodges*

(Address) *451 Grindall St*

15-

MAY 30 1915

ROBERT J. KRAUTER,

Marital Permit Clerk

REGISTRAR

16-DATE OF DEATH

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 27, 191*5*, to *May 27*, 191*5*.

that I saw him alive on *May 27*, 191*5*.

and that death occurred, on the date stated above, at *5:00* m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(Duration) *2* yrs. *10* mos. ds

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *W. H. Smith* M. D.

May 29, 191*5* (Address) *28th St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grav Hall Co

May 31, 191*5*

20-UNDERTAKER

ADDRESS

W. H. Cook

1003 N. Baltimore

C85686 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 C85686

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2520 E. Preston ST., 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2520 E. Preston St.; unknown yrs., unknown mos., unknown ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow (Write the word.)6-DATE OF BIRTH, May, 1845 (Month) (Day) (Year)7-AGE, 70 yrs., unknown mos., unknown ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Ireland10-NAME OF FATHER, Thomas Kennedy11-BIRTHPLACE OF FATHER (State or Country), Ireland12-MAIDEN NAME OF MOTHER, unknown13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Barnes
(Address) 2520 E. Preston St.

15-

MAY 30 1915

ROBERT KRAUTER

Filed..... 191..... Mar. 1. Permit. Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 27, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 26, 1915, to May 27, 1915, that I saw h or alive on May 27, 1915, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Central Nervous System
(Duration)..... yrs..... mos..... 2 ds.CONTRIBUTORY (Secondary) None(Signed) Inspector M. D. May 20, 1915. (Address) 125 E. Blue

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ken Cathedral CemMay 31, 1915

20-UNDERTAKER

ADDRESS

John J. MoranBarbours

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85687

CERTIFICATE OF DEATH.

6117 C85687

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 211 S Chester

ST. 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 211 S Chester St.

St. yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

April, 1913
(Month) (Day) (Year)

7-AGE,

2 yrs. 1 mos. da.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Baltimore Md.

10-NAME OF FATHER,

Mendall Boyd

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Nora Kelly

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nora Boyd

(Address) 211 S Chester St.

15-

MAY 30 1915 ROBERT KRAUTER, Registrar.

Filed

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25 1915, to May 29 1915, that I saw him alive on May 29 1915, and that death occurred, on the date stated above, at 7 P. m. The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed)

May 29 1915 (Address) 15 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

May 31, 1915

20-UNDERTAKER

John A. Moran & Ann

ADDRESS

Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *7* WARD)

REGISTERED NO. C

2-FULL NAME *Jeannette Butz*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1923 E. Chase St.* St.; *50* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*6-DATE OF BIRTH, *Don't know, 1843*

(Month)

(Day)

(Year)

7-AGE, *72*

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *Don't know*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Don't know*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *John A. Moran*(Address), *1760 Bank St.*

15-MAY 30 1915

ROBERT KRAUTER,

Municipal Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 28, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 26* 1915, to *May 28* 1915, that I saw her alive on *May 28* 1915, and that death occurred, on the date stated above, at *2 a. m.*

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) *Myocarditis*

(Duration).....yrs.....mos.....ds.

(Signed) *J. W. Vinton, Cliff* M. D.*May 28, 1915* (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutional Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? *unknown*Former or usual residence *1923 E. Chase St.*19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer*DATE OF BURIAL, *May 31, 1915*20-UNDERTAKER *John A. Moran*ADDRESS *Bank St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85689

CERTIFICATE OF DEATH.

30 C85689

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2033 Penrose ave ST.; 30 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2033 Penrose ave St.; yrs. 9 mos. 10 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

August 18, 1914
(Month) (Day) (Year)

7-AGE,

9 yrs. 10 mos. 10 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Harry A. Dumphy

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Winifred Pindley

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. M. G. G. G.

(Address) North Penrose

15-

MAY 30 1915

ROBERT . KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 28, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 2, 1915, to May 28, 1915,

that I saw her alive on May 2, 1915,

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia, pneumonia

(Duration) yrs. 5 mos. 21 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. 5 mos. 4 ds.

(Signed) E. J. G. G. G. M. D.

May 29, 1915 (Address) 817 North Penrose

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery May 31, 1915

20-UNDERTAKER

ADDRESS

W. J. G. G. G. North Penrose

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85620

HEALTH DEPARTMENT-CITY OF BALTIMORE

PLACE OF DEATH

CERTIFICATE OF DEATH

91 C85620

CITY OF BALTIMORE (No. *1804 Loman*)

2-FULL NAME *Genzie Couter*

(Residence in Baltimore: No. *1804 Loman* St. *1* WARD *15*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE
Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word)
Single

6-DATE OF BIRTH

Feb 14

(Month)

14

(Day)

1915

(Year)

7-AGE

2

3

15

ds.

15

hrs.

1

min.

If LESS than

1 day, ----- hrs.

or ----- min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE
(State or country)

Balto. Md.

10-NAME OF FATHER

Genzie Couter

11-BIRTHPLACE OF FATHER
(State or country)

Penn.

12-MAIDEN NAME OF MOTHER

Rosie Snell

13-BIRTHPLACE OF MOTHER
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rosie Couter (mother)

(Address)

1804 Loman St.

15.

MAY 30 1915

Filed

ROBERT KRAUTER,
Funeral Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 29

(Month)

29

(Day)

1915

(Year)

17.

I HEREBY CERTIFY, That I attended deceased from

May 24, 1915, to *May 29*, 1915,

that I saw him alive on *May 29*, 1915,

and that death occurred, on the date stated above, at *8:45 A. M.*

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Contributory
(SECONDARY)

(Duration)

Asphyxia

yrs.

5

mos.

5

ds.

(Signed)

T. E. Daugherty

(Duration)

yrs.

1

mos.

1

ds.

May 29

, 1915

(Address)

1604 Bellvue Ave.

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

where was disease contracted,

if not at place of death?

Former or

usual residence

yrs.

mos.

In the

State

yrs.

mos.

ds.

19-PLACE OF BURIAL OR REMOVAL

St. Auburn

DATE OF BURIAL

May 31, 1915

20-UNDERTAKER

James H. Dunn

ADDRESS

1303 Preston

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1465 N. Carey street, ST. 15 WARD)

2-FULL NAME Viola Hall,

(Residence in Baltimore: No. 1465 N. Carey street, St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, January 8th, 1901. (Month) (Day) (Year)

7-AGE, 14 yrs., 4 mos., 19 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Samuel Hall, 11-BIRTHPLACE OF FATHER, (State or Country), Maryland, 12-MAIDEN NAME OF MOTHER, Jennie Bell, 13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Jennie Hall, Mother, (Address) 1465 N. Carey street.

15- MAY 30 1915 ROBERT A. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 27th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to her death on the day stated above. (Inquest, au- topsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) F. F. ... M. D. (Coroner.) May 28th 1915 (Address) 3310 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn, DATE OF BURIAL, May 31 1915, 20-UNDERTAKER, James H. Dennis, ADDRESS, 1303 Prentiss St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085692

HEALTH DEPARTMENT—CITY OF BALTIMORE

085692

104

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 1518 Eastern Ave ST. 3 WARD) REGISTERED NO. C
2-FULL NAME Charles, D. Falkenheer
(Residence in Baltimore: No. 1518 Eastern Ave St. 3 mos. 7 ds.)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
(Write the word.)
6-DATE OF BIRTH, Feb 21, 1915
(Month) (Day) (Year)
7-AGE, 3 yrs. 3 mos. 7 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.
10-NAME OF FATHER, Casper Falkenheer
11-BIRTHPLACE OF FATHER (State or Country), Baltimore
12-MAIDEN NAME OF MOTHER, May Davis
13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) May Falkenheer
(Address) 1518 Eastern Ave

15- MAY 30 1915 ROBERT KRAUTER,
Filer Marial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 28, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Gastritis
hemorrhagic
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds.
(Signed) David W. Jones M. D. (Coroner.)
May 29, 1915 (Address) 3116 Occoquan Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Carmel DATE OF BURIAL, May 31, 1915
20-UNDERTAKER, Mundell Daffel ADDRESS, 528 Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85693

CERTIFICATE OF DEATH

C85693

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD

FULL NAME

(Residence in Baltimore: No.

St.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

Single

6. DATE OF BIRTH

July

25, 1913

7. AGE

1 yrs. 10 mos. 6 ds.

If LESS than
1 day, hrs.
or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE
(State or country)

Balto Md.

PARENTS

10. NAME OF FATHER

Harry Bender

11. BIRTHPLACE OF FATHER
(State or country)

Balto Md

12. MAIDEN NAME OF MOTHER

Mabel Ridenbough

13. BIRTHPLACE OF MOTHER
(State or country)

Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Bender

(Address)

McMiners Md

MAY 30 1915

Filed

191

ROBERT J. KRAUTER

Sanitary Permit Clerk

REGISTRAR

G. A. M.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

30, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 29, 1915, to May 30, 1915.

that I saw him alive on May 29, 1915.

and that death occurred, on the date stated above, at 5-15 A.M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) yrs. mos. 2 ds

Contributory
(SECONDARY)

same

(Duration) yrs. mos. 2 ds

(Signed) Geo. S. M. Kieffer M. D.

May 30, 1915 (Address) Morlake Park Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Golden Park

DATE OF BURIAL

May 31, 1915

20. UNDERTAKER

Joseph Brook

ADDRESS

1002 7 Balto

SA

C85694

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85694

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Union Protestant Cemetery

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST. 14 WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs. John Weiss (Carie) Weiss

(Residence in Baltimore: No.

Bradford Pa

St.: yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

July 17, 1867

7-AGE,

57 yrs. 10 mos. 13 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Buffalo N.Y.

10-NAME OF FATHER,

Meyer Schuman

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Hanna Weil

13-BIRTHPLACE OF MOTHER (State or Country),

France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Weiss

(Address)

Bradford Pa

15-MAY 31 1915

HARRY O. ANDREWS,

Filed 1915 Bartlett-Formit-Clark Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 30, 1915

17- I HEREBY CERTIFY, That I attended deceased from

May 25 1915, to May 30 1915,

that I saw her alive on May 30 1915,

and that death occurred, on the date stated above, at 8:10 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 3 yrs. 10 mos. 13 ds.

CONTRIBUTORY (Secondary)

Broncho-Pneumonia

(Duration) 5 yrs. 10 mos. 13 ds.

(Signed) J. J. Davis M. D.

May 30, 1915. (Address) U.S.A.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Bradford Pa.

19-PLACE OF BURIAL OR REMOVAL,

Bradford Pa

DATE OF BURIAL,

May 31, 1915.

20-UNDERTAKER

David Boudheim

ADDRESS

118 E. Main St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85695

CERTIFICATE OF DEATH

92 C85695

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *19 E. Church St.*)

ST. *22* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James H. Carter*

Residence in Baltimore: No. *19 E. Church St.* Sr.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *colored* 5-SINGLE, MARRIED *widowed*, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH *Unknown*, 1874 (Month) (Day) (Year)

7-AGE *41* yrs. — mos. — ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work *Steward*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country) *Virginia*

10-NAME OF FATHER *James Carter Sr.*

11-BIRTHPLACE OF FATHER (State or country) *Virginia*

12-MAIDEN NAME OF MOTHER *Susan Thomas*

13-BIRTHPLACE OF MOTHER (State or country) *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harry Buschrod*
(Address) *19 E. Church St.*

MAY 31 1915

Filed

, 191

REBEY O. ANDREWS,

MARIAL PERMIT CLERK

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May *29*, 191*5*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 3, 191*5*, to *May 29*, 191*5*.

that I saw him alive on *May 26*, 191*5*.

and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH* was as follows:

Grippe Pneumonia

(Duration) — yrs. — mos. *26* ds

Contributory (SECONDARY)

Exhaustion

(Duration) — yrs. — mos. *26* ds

(Signed),

W. A. Smith

M. D.

May 30, 191*5* (Address) *528 K. Market*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Int. Auburn *May 31*, 191*5*

20-UNDERTAKER

ADDRESS

L. L. Brownson *108 W. Montz St.*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 3610 Connecticut Avenue St. 13 WARD)

2-FULL NAME Sarah A. Pearce

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3610 Connecticut Avenue St. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX female 4-COLOR OR RACE white 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) single

6-DATE OF BIRTH October 1861 (Month) (Day) (Year)

7-AGE 53 yrs. 7 mos. ds. or min. 2 If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work Housekeeper (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore, County Md

10-NAME OF FATHER Levi Pearce

11-BIRTHPLACE OF FATHER (State or country) Pennsylvania

12-MAIDEN NAME OF MOTHER Mary A. Lee

13-BIRTHPLACE OF MOTHER (State or country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Mrs. F. M. Likens (Informant)

(Address) 2862 Woodbrook Ave.

MAY 31 1915

HARRY O. ANDREWS, Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 29, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 23, 1915, to, May 29, 1915, that I saw her alive on May 29, 1915,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral Valve Insufficiency

Contributory (SECONDARY) (Duration) 4 yrs. mos. ds. Dr. J. B. Brown & Mary J. Macdonald

(Signed) A. J. Shelley M. D. May 30, 1915 (Address) 3749 Roland Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL St. Mary's cemetery May 31, 1915

20-UNDERTAKER ADDRESS A.S. Marshall 3539 Falls Road.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Particulars should be stated EXACTLY. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85697

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

522 Munsey St. 17 WARD)

Mattie Thomas

522 Munsey St.

St. — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Col

5-~~SINGLE~~
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widow

6-DATE OF BIRTH

July 19, 1866
(Month) (Day) (Year)

7-AGE

48 yrs. 10 mos. 10 ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laundress

9-BIRTHPLACE

(State or country)

Md.

10-NAME OF FATHER

Jas. Smith

11-BIRTHPLACE OF FATHER
(State or country)

Md.

12-MAIDEN NAME OF MOTHER

Ellen Gray

13-BIRTHPLACE OF MOTHER
(State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel Carson

(Address)

716 Penna ave

MAY 31 1915

HARRY O. ANDREWS,

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 21, 1915, to May 29, 1915.

that I saw her alive on May 28, 1915.

and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Ac. Nephritis

(Duration) — yrs. — mos. 8 ds

Contributory
(SECONDARY)

(Duration) — yrs. — mos. 5 ds.

(Signed)

Frank C. Wagner, M.D.

May 20, 1915 (Address) 1006 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount Auburn

June 1, 1915

20-UNDERTAKER

Samuel Carson

ADDRESS

916 Penna ave

C85698

HEALTH DEPARTMENT--CITY OF BALTIMORE

66

C85698

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *Aged Home W.E. Church 14* ST. WARD)2-FULL NAME *Benjamin Morgan*(Residence in Baltimore: No. *1622 Dund Hill Ave* St.; *3* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11L.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widow

6-DATE OF BIRTH

Unknown, 1830
(Month) (Day) (Year)

7-AGE

85
yrs. mos. ds. or min.?If LESS than
1 day, hrs.
min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Ex-Cookman*9-BIRTHPLACE
(State or country)*Maryland*

10-NAME OF FATHER

*Unknown*11-BIRTHPLACE OF FATHER
(State or country)*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or country)*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Isabella B. Burt(Address) *1622 Dund Hill Ave*

15-

MAY 31 1915

HARRY O. ANDREWS,

Burial Permit Clerk,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1a-DATE OF DEATH

May 29, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from
Oct 1, 1915, to, *May 24*, 1915,
that I saw him alive on *May 28*, 1915,
and that death occurred, on the date stated above, at *9:4* m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Rt Side
(Duration) *2* yrs. mos. ds.Contributory
(SECONDARY)*Arterio Sclerosis age*
(Duration) *3* yrs. mos. ds.(Signed) *J. H. Tradome* M. D.
May 30, 1915 [Address] *1209 N. Broadway*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *3* yrs. mos. ds. In the State yrs. mos. ds.Where was disease contracted, If not at place of death? *Aged Home W.E. Church*

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mt. Auburn An**May 31, 1915*

20-UNDERTAKER

ADDRESS

John H. Tradome 142 W. Hill St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

C85699

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85699

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins St.* ST. *17* WARD)

2-FULL NAME *Howard Smith*

(Residence in Baltimore: No. *1121 Pa Ave.* St. *-* yrs. *-* mos. *-* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

Sept

28

1914

(Month)

(Day)

(Year)

7-AGE

yrs. *8*

mos.

ds.

or

min.?

If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9-BIRTHPLACE

(State or country)

Maryland

10-NAME OF FATHER

Stuart Smith

11-BIRTHPLACE OF FATHER

Va.

12-MAIDEN NAME OF MOTHER

Mary Edgars

13-BIRTHPLACE OF MOTHER

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. B. Curry

(Address)

1121 Pa Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

29

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 28, 1915, to

May 29, 1915,

that I saw him alive on

May 29, 1915,

and that death occurred, on the date stated above, at *10:45* a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Acute Primary

X

(Duration)

yrs.

mos.

ds.

2

Contributory (SECONDARY)

malnutrition

(Duration)

yrs.

mos.

ds.

?

(Signed),

G. A. Batten

M. D.

May 30, 1915

(Address)

1121 Pa Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

State

yrs.

mos.

ds.

1

8

Where was disease contracted, If not at place of death?

Former or usual residence

1121 Pa Ave.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laurel Hill

5/31/15

20-UNDERTAKER

ADDRESS

Sam'l B. Baskin 57801 Biddle

MAY 31 1915

Filed

191

HARRY O. ANDREWS,

Burial Permit Clerk.

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85-00

CERTIFICATE OF DEATH.

79

C85-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 E Oliver ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ellen Lee Terry

(Residence in Baltimore: No. 1739 E Oliver St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widow (Write the word.)

6-DATE OF BIRTH, May (Month) 29 (Day), 1915 (Year)

7-AGE, 69 yrs., mos., ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Charles C Ind.

10-NAME OF FATHER, John B. Wilkerson

11-BIRTHPLACE OF FATHER (State or Country), Charles C Ind.

12-MAIDEN NAME OF MOTHER Chlor Ann Baer

13-BIRTHPLACE OF MOTHER (State or Country), Charles C Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert W. Terry

(Address) 1739 E Oliver St.

15- MAY 31 1915 HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 29 (Day), 1915 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 24 1915, to May 29 1915, that I saw her alive on May 28 1915, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows: Chronic Endocarditis

(Duration) 1 yrs., mos., ds. CONTRIBUTORY (Secondary) Catarrhal Enteritis

(Duration) 1 yrs., mos., ds. (Signed) Chas. Macdonald M. D.

May 29, 1915. (Address) 1540 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Louder Park Cemetery DATE OF BURIAL, June 1, 1915.

20-UNDERTAKER Albert C. Fuller ADDRESS 221 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85701

CERTIFICATE OF DEATH

64 C85701

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; 40 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

white

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Sept 17, 1850
(Month) (Day) (Year)

7-AGE

64 yrs. 8 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Plaster

9-BIRTHPLACE

(State or country)

Maryland

10-NAME OF FATHER

Hanson Garrettson

11-BIRTHPLACE OF FATHER

(State or country)

Ind.

12-MAIDEN NAME OF MOTHER

Laura Bruff

13-BIRTHPLACE OF MOTHER

(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

MAY 31 1915

HARRY O. ANDREWS,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 30th, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

August 30, 1914, to May 30th, 1915.

that I saw him alive on May 30th, 1915.

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

Contributory (SECONDARY)

Obstructive Phlebitis
(Duration) yrs. 9 mos. ds.

(Signed) Stephen J. Sheeueau M. D.
May 30, 1915 (Address) 1227 W. Lafayette Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Garretson Ind

DATE OF BURIAL

June 1, 1915

20-UNDERTAKER

Chas. E. French

ADDRESS

802 Madison Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

RE 105- C85702

REGISTERED NO. C

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and All out No. 18.)

(Residence in Baltimore: No.

St.: 29 yrs., mos., ds.)

MEDICAL CERTIFICATE OF DEATH.

4-COLOR OR RACE

**SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED**
(Write the word.)

6-DATE OF BIRTH.

Nov 26, 1862
(Month) (Day) (Year)

T-AGE

62 yrs. 6 mos. 4 da

If LESS than 1 day,
....hrs. or.....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, establishment in which employed (or employer).....

P-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE
OF FATHER
(State or Country)

12-MAIDEN NAME
OF MOTHER /

**1.3-BIRTHPLACE
OF MOTHER
(State or Country)**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Wilhelmine Kuhn

(Address) 2236 Cambridge St

18-

Filed....., 191.. **Clerk of Court**
Registrar.

18-DATE OF DEATH.

May 30, 1918
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 27 1915, to May 30 1915,
that I saw him alive on May 27 1915,
and that death occurred, on the date stated above, at 7:00 p.m.

The CAUSE OF DEATH* was as follows:

Gradual Ulcer, Perforated.
(Perforated May 27, 1915)
(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

..... (Duration) yrs. mos. da.
(Signed) M. D.
May 30, 1915. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos. 3 ds. is the State 20 yrs..... mos..... ds.

Where was disease contracted, if not at place of death? 2236 Cambridge St

Former or usual residence..... 2236 Cambridge St

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.
June 1., 1915.

20-UNDERTAKER

ADDRESS

H. Sander & Sons, 710 8th St.

C85-03

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

C85-03

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2508 Hudson St. ST. 1 WARD)

2. FULL NAME

(Residence in Baltimore: No. 2508 Hudson St. St. 1 yrs. 1 mos. 1 da.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX.

Female

4. COLOR OR RACE.

White

5. SINGLE,

Widowed
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH.

Not known, 1
(Month) (Day) (Year)

7. AGE.

about 63 years
yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8. OCCUPATION:

(a) Trade, profession, or particular

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE,
(State or Country).Md

10. NAME OF FATHER.

Not known11. BIRTHPLACE OF FATHER
(State or Country).not known

12. MAIDEN NAME OF MOTHER

not known13. BIRTHPLACE OF MOTHER
(State or Country).not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Margaret Weber
804 S. Port St.

15.

MAY 31 1915

Filed

191. Serial Permit 0101
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH,

May 28, 1915.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 27 1915, to May 28 1915,
that I saw her alive on May 28 1915,
and that death occurred, on the date stated above, at 2:40 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 2 yrs. 1 mos. 1 da.CONTRIBUTORY
(Secondary)(Duration) 3 yrs. 3 mos. 3 da.

(Signed)

5/29, 1915. (Address) 1201 E. 1st St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL.

Trinity Cemetery

DATE OF BURIAL.

May 31, 1915.

20. UNDERTAKER

H. Sanders & Sons

ADDRESS

1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85-04

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *801 Aisquith* ST. *10* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *801 Aisquith* St.: — yrs. — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) *Widow*

6-DATE OF BIRTH

February 22, 1893
(Month) (Day) (Year)

7-AGE

71 yrs. *3* mos. *9* da.

If LESS than 1 day,

...hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

*Not known*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Not known*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Helena L. Tricke*(Address) *801 Aisquith St.*

15-

Filed

MAY 31 1915

HARRY O. ANDREWS,

Bureau of Vital Records
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 30, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 1, 1915, to May 30, 1915,*that I saw him alive on *May 29, 1915,*and that death occurred, on the date stated above, at *2309* am.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) *6* yrs. *6* mos. *6* da.CONTRIBUTORY
(Secondary)(Duration) *Old age*(Signed) *H. Russell M.D.* M. D.*6/30, 1915* (Address) *801 Aisquith St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *71* yrs. *3* mos. *9* da. In the State *71* yrs. *3* mos. *9* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Matthews Cemetery, June 1, 1915.

20-UNDERTAKER

ADDRESS

Robt. J. Turner, 1421 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85705

CERTIFICATE OF DEATH.

91

C85705

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *1409 Gough* ST.; *9* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1409 Asguth St.*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; — yrs., 10 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *July 3, 1914* (Month) (Day) (Year)7-AGE, *10 yrs., 27 mos., 27 ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Lawrence Grou*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Corrie Evans*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lawrence Grou*(Address) *1409 Asguth St.*

15-

Filed *MAY 31 1915* HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 29, 1915* (Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *May 25, 1915*, to *May 29, 1915*, that I saw *him* alive on *May 29, 1915*, and that death occurred, on the date stated above, at *7:30 p.m.* The CAUSE OF DEATH* was as follows:*Pneumonia*(Duration) yrs. mos. ds. *6*CONTRIBUTORY (Secondary) *Cardiac Disease*

(Duration) yrs. mos. ds.

(Signed) *W. J. [Signature]* M. D. *May 30, 1915* (Address) *1200 8th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Baltimore, Md. May 31, 1915

20-UNDERTAKER ADDRESS

W. J. Turner 1441 11th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85-66

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85-66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1975 N. Calhoun Ave. ST. 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1975 N. Calhoun Ave. St.: yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) single

6-DATE OF BIRTH

July 17, 1914
(Month) (Day) (Year)

7-AGE

yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Charles N. Patterson

11-BIRTHPLACE OF FATHER, (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Emma F. Peterson

13-BIRTHPLACE OF MOTHER, (State or Country),

New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles N. Patterson(Address) 1975 N. Calhoun Ave.

15-

MAY 31 1915 HARRY O. ANDREWS,Filed..... 191..... Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 29, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 29 1915, to May 29 1915,that I saw him alive on May 29 1915,and that death occurred, on the date stated above, at 6:30 Pm.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(Duration)..... yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) Jacob Fisher M. D.May 28 1915. (Address) 1926 E. Long Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

McClure Cem. May 31 1915.

20-UNDERTAKER ADDRESS

Reid J. Turner 1442 N. Broad.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85707

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85707

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *941 Druid Hill Ave.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *941 Druid Hill Ave.* St.; *34* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-MARRIED, *Married*
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

51 yrs. *—* mos. *—* ds. If LESS than 1 day.
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Grocer*9-BIRTHPLACE,
(State or Country),*Russia*

10-NAME OF FATHER,

*Isaac Cohen*11-BIRTHPLACE OF FATHER
(State or Country),*Russia*

12-MAIDEN NAME OF MOTHER

*Annie Frieda*13-BIRTHPLACE OF MOTHER
(State or Country),*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lena L. L. L.*(Address) *941 Druid Hill Ave.*

15-

MAY 31 1915

HARRY O. ANDREWS,

Burial Permit Officer
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 30, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 30, 1915*, to *May 30, 1915*, that I saw him alive on *May 30, 1915*, and that death occurred, on the date stated above, at *7:30 A.M.*

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
(Duration) *—* yrs. *—* mos. *3* ds.

CONTRIBUTORY

Acute Indigestion & Fatty degeneration of heart
(Secondary) (Duration) *—* yrs. *—* mos. *3* ds.(Signed) *M. A. W. W. W.**May 30, 1915* (Address) *1804 Madison St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

941 Druid Hill Ave.

19-PLACE OF BURIAL OR REMOVAL,

Forest Roadside

DATE OF BURIAL,

May 31, 1915

20-UNDERTAKER

A. Johnson & Co. Baltimore

ADDRESS

1107 E

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85-08

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85-08

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 725 N. Eden ST. 7 WARD)

2-FULL NAME Baby Liferman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11L)

(Residence in Baltimore: No. 725 N. Eden St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

Single

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

May

29

1915

(Month)

(Day)

(Year)

7-AGE

If LESS than

1 day, hrs.

yrs.

mos.

ds.

or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

MD

10-NAME OF FATHER

Dave Liferman

11-BIRTHPLACE OF FATHER
(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Annie Aronoff

13-BIRTHPLACE OF MOTHER
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dave Liferman

(Address)

725 N. Eden St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

30

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 29

1915

to, May 30

1915

that I saw him alive on

May 30

1915

and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration)

yrs.

mos.

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

E. D. Plasse

M. D.

May 31

1915

[Address]

J. H. H.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Hebrew Mt. Cemetery

DATE OF BURIAL

May 31

1915

20-UNDERTAKER

Levinson & Bro

ADDRESS

101 E Baltimore

19-FILED

MAY 31 1915

HARRY O. ANDREWS,

FILED

191

Registrar

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85709

CERTIFICATE OF DEATH

C85709

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

1033 E Biddle

ST.

WARD

2-FULL NAME

Alan Miles Mett

(Residence in Baltimore: No.

1033 E Biddle

Str.

yrs.

4 mos. 1 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

January 29th, 1915
(Month) (Day) (Year)

7-AGE

4 yrs. 1 mos. 1 ds. or min.?

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Baltimore, Md.

10-NAME OF FATHER

Milton H. Mett

11-BIRTHPLACE OF FATHER (State or country)

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Laura V. Tidmore

13-BIRTHPLACE OF MOTHER (State or country)

Fredrick, Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mm. Mett & Mett

(Address) 1033 E Biddle St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 30th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 27th, 1915, to May 30th, 1915.

that I saw him alive on May 29th, 1915.

and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Splenic anaemia
(Von Jaekel's disease)

(Duration) 3 yrs. 3 mos. 1 ds.

Contributory (SECONDARY)

Exhaustion

(Duration) 3 yrs. 3 mos. 1 ds.

(Signed) C. W. Mitchell M. D.

May 30, 1915 (Address) 9 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Oak Lawn Cemetery

DATE OF BURIAL

June 1, 1915

20-UNDERTAKER

Henry Horckel

ADDRESS

1301 E Engle St

15-MAY 31 1915

Filed

HARRY O. ANDREWS,

Marital Permit Clerk REGISTRAR

C85-10

HEALTH DEPARTMENT—CITY OF BALTIMORE.

C85-10

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 1 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

November 30

1913

(Month)

(Day)

(Year)

7-AGE,

1 yrs. 6 mos. ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Baltimore Md

PARENTS.

10-NAME OF FATHER,

Joseph H. Fuchs

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Elizabeth Fuchs

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Joseph H. Fuchs

(Address)

939 N. Collingwood Ave.

MAY 31 1915.

Filed

191

HARRY O. ANDREWS,

Baltimore City Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 27

(Month)

30

(Day)

1915

(Year)

I HEREBY CERTIFY, That I attended deceased from

May 27, 1915, to May 30, 1915,

that I saw him alive on May 29, 1915,

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Catarrhal Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exacerbation

(Duration) yrs. mos. ds.

(Signed) George J. Hartman, M. D.

May 30, 1915 (Address) 1121 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

C85711

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 C85711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asy.* ST. 14 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Leo Wright(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. 6 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Sept 13th, 1914.
(Month) (Day) (Year)

7-AGE,

8 yrs. 16 mos. 16 da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

MAY 31 1915

HARRY O. ANDREWS,

Filed 191... Serial Permit Officer Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 29th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 25 1915, to May 29 1915,
that I saw him alive on *May 29 1915,*and that death occurred, on the date stated above, at *10:06 a.m.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) yrs. mos. *4* da.CONTRIBUTORY *Malnutrition*
(Secondary)(Duration) yrs. mos. *2* da.(Signed) *Colmer G. Hall* M. D.*May 29, 1915.* (Address) *1617 E. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 6 mos. In the State yrs. 8 mos. 16 da.

Where was disease contracted, if not at place of death? *St Vincent's Infant Asylum*Former or usual residence *St Vincent's Inf Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral May 31, 1915.

20-UNDERTAKER

ADDRESS

H. H. Hayes & Sons 616 Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85-12

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85-12

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1207 N. Gilman St. ST. 16 WARD)

2-FULL NAME James H. Parks (Parks)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1207 N. Gilman St. St. 16 yrs. 35 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6-DATE OF BIRTH Sept. 24, 1843 (Month) (Day) (Year)

7-AGE 71 yrs. 8 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION Teamster (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Maryland

10-NAME OF FATHER Joshua Parks

11-BIRTHPLACE OF FATHER (State or country) Baltimore Md.

12-MAIDEN NAME OF MOTHER Sarah Pitts

13-BIRTHPLACE OF MOTHER (State or country) Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Annie Parks

(Address) 1207 N. Gilman St.

15. MAY 31 1915 HARRY O. ANDERSON, Registrar

20-UNDERTAKER Joe B. Cook

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May - 29, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May - 17, 1915, to May - 29, 1915, that I saw him alive on May - 29 - 1915, and that death occurred, on the date stated above, at 11:30 a.m. The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart (Duration) 12 yrs. 12 mos. 12 ds.

Contributory Organic Heart Disease Gastritis (Duration) Don't Know ds.

(Signed) Marlin W. Shorb M. D. May 30, 1915 (Address) 806 N. Fulton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Baltimore DATE OF BURIAL June 1 - 1915

ADDRESS 1003 W. Baltimore St.

C85-13

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85-13

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *312 Pearl*)ST.: *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *312 Pearl*)

St.: — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*colored*5-SINGLE, *married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown
(Month) (Day) (Year)

7-AGE,

5-7 yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Landress*9-BIRTHPLACE,
(State or Country),*md*

10-NAME OF FATHER,

*Robert Leonard*11-BIRTHPLACE OF FATHER
(State or Country),*md*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert H. Ashell*(Address) *312 Pearl St*

15-

Filed *MAY 31 1915*

HARRY O. ANDREWS,

REGISTERED

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 28 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Mar 30 1915* to *May 28 1915*that I saw her alive on *May 28 1915*and that death occurred, on the date stated above, at *6:40 p.m.*

The CAUSE OF DEATH* was as follows:

Interstitial nephritis
about 10 weeks
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)*Excess*
(Duration) yrs. mos. ds.(Signed) *Wm. H. Truening* M. D.*May 29 1915* (Address) *1419 N. Main St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mount Auburn City *May 31, 1915*

20-UNDERTAKER

ADDRESS

Alfred J. Ireland *144 Schuchter*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85-14

C85-14

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Holmesman Gen Hospital* ST.; *18* WARD)

2-FULL NAME

(Residence in Baltimore: No. *839 Baborga* St.; *7* yrs., *—* mos., *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Caucasoid*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

28

yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laundress

9-BIRTHPLACE,

(State or Country), *Ind*

PARENTS.

10-NAME OF FATHER,

Frank Brown

11-BIRTHPLACE OF FATHER

(State or Country), *Dc*

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country), *Unknown*

14-THIS ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Wilson*(Address) *839 Baborga St*

15-

MAY 31 1915

Filed

191

HARRY O. ANDREWS,

Baptist Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May**30**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 13 1915, to *May 30 1915*,that I saw her alive on *May 29 1915*,and that death occurred, on the date stated above, at *2.15 a.m.*

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation and Dilated Heart(Duration) *2* yrs. *—* mos. *—* ds.CONTRIBUTORY *Anasarca*

(Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.(Signed) *Charles E. Clark* M. D.191... (Address) *1310 N. Gilman*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *16* yrs. *—* mos. *—* ds. In the State *48* yrs. *—* mos. *—* ds.Where was disease contracted, if not at place of death? *839 Baborga*Former or usual residence *839 Baborga St*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Evergreen cemetery *May 31, 1915*

20-UNDERTAKER

ADDRESS

Edmund J. Ireland *11412 Union*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

C85715

PLACE OF DEATH

CITY OF BALTIMORE (No. *302 N Gay St.* ST. *5* WARD)

FULL NAME

Edward A. Byrne

(Residence in Baltimore: No. *302 N Gay St.* ST. *5* yrs. *11* mos. *18* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married* (Write the word)

6-DATE OF BIRTH *June 11, 1951* (Month) (Day) (Year)

7-AGE *63* yrs. *10* mos. *18* ds. IF LESS than 1 day, hrs. or min.?

8-OCCUPATION *Inductee* (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Balto. Md*

10-NAME OF FATHER *James P. Byrne*

11-BIRTHPLACE OF FATHER (State or country) *Baltimore*

12-MAIDEN NAME OF MOTHER *Mary D. Dyer*

13-BIRTHPLACE OF MOTHER (State or country) *Annapolis Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Edward A. Byrne*

(Address) *302 N Gay St.*

15. MAY 31 1915 HARRY O. ANDREWS, REGISTRAR

Filed MAY 31 1915 Burial Permit No. 101

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *5* *29*, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 23*, 1915, to *May 29*, 1915, that I saw him alive on *May 29*, 1915, and that death occurred, on the date stated above, at *11:45* pm. The CAUSE OF DEATH* was as follows:

Tubercular Mesenteria

(Duration) *2* yrs. *10* mos. *18* ds.

Contributory (SECONDARY) *Arteriosclerosis*

(Duration) *8* yrs. *10* mos. *18* ds.

(Signed) *Edward A. Byrne* M. D.

May 30, 1915 (Address) *228 Carroll St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted? If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *New Cathedral Cemetery* DATE OF BURIAL *June 1*, 1915

20-UNDERTAKER *W. J. Schaeffer, Inc.* ADDRESS *8 S Front St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85716

CERTIFICATE OF DEATH.

120 C85716
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2207 Jefferson St. 6 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2207 Jefferson St.

St.: 40 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

July 12th 1854
(Month) (Day) (Year)

7-AGE,

60 yrs. 10 mos. 17 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

John Rank

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Anna Schuler

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Rank

(Address)

2207 Jefferson St.

15- MAY 31 1915

Filed..... 1915

HARRY O. ANDREWS,

Married Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 25 1915, to May 29 1915, that I saw him alive on May 28 1915, and that death occurred, on the date stated above, at 3.15 p.m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency
Chronic interstitial nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Pulmonary congestion

(Duration) yrs. mos. ds.

(Signed) H. B. P. M. D.

May 20, 1915 (Address) 200 N. Park Pl. Ger.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Ave.

DATE OF BURIAL,

June 1, 1915

20-UNDERTAKER

Fitz & Fisher

ADDRESS

4038 N. Park Pl.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85717

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85717

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 114 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME

(Residence in Baltimore: No. Coleman Mc St. 114 yrs. 1 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE. <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <u>Married</u> (Write the word.)
6-DATE OF BIRTH <u>February 22, 1853</u> (Month) (Day) (Year)		
7-AGE, <u>62</u> yrs. <u>3</u> mos. <u>9</u> ds.		If LESS than 1 day, ...hrs. or...min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer).....		

9-BIRTHPLACE,
(State or Country).Maryland

PARENTS.

10-NAME OF FATHER.

Albert P. Parks11-BIRTHPLACE OF FATHER
(State or Country).Maryland

12-MAIDEN NAME OF MOTHER

Elizabeth Braxley13-BIRTHPLACE OF MOTHER
(State or Country).Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse P. Coleman (son)(Address) (Pres.) Betterton Md.

15-

HARRY O. ANDREWS,

MAY 31 1915 191. Burial Permit. CLAY
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 31, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

April 10, 1915, to May 31, 1915,that I saw her alive on May 30, 1915,and that death occurred, on the date stated above, at 12:58 A.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation (and Shunt)CONTRIBUTORY
(Secondary)(Duration) 1 yrs. 1 mos. 1 ds.Cholera and Cholera toxin(Duration) 1 yrs. 1 mos. 1 ds.(Signed) William H. Hanchard, M.D.May 31, 1915 (Address) Md. Gen. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 1 yrs. 20 ds. In the 62 yrs. 3 mos. 9 ds.Where was disease contracted, if not at place of death? Coleman's near Betterton Md.Former or usual residence Coleman's near Betterton Md.

19-PLACE OF BURIAL OR REMOVAL.

Betterton Md.

DATE OF BURIAL.

May 31, 1915

20-UNDERTAKER

Wm. Lickner & Son

ADDRESS

North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85718

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85718

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *417 Druid Hill Ave* St.: *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *417 Druid Hill Ave* St.: *17* yrs. *10* mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

*of 3**1915*

7-AGE.

26

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore City

PARENTS.

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

unknown

12-MAIDEN NAME OF MOTHER

Angeline Jones

13-BIRTHPLACE OF MOTHER (State or Country),

Mo.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ms. Maggie Robinson*(Address) *417 Druid Hill Ave*

15-

MAY 31 1915

HARRY O. ANDREWS,

Filed..... 1915 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

5/28, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

5/28 191*5*, to *5/28* 191*5*that I saw him alive on *5/28* 191*5*and that death occurred, on the date stated above, at *10 P.* m.

The CAUSE OF DEATH* was as follows:

Gastric cancer

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed).....

5/28, 191*5*, (Address) *St. Louis*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

May 31, 1915

20-UNDERTAKER

John A. Bishop

ADDRESS

1107

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85719

129 C85719

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hosp

REGISTERED NO. C

CITY OF BALTIMORE: (NO

Lombard & Greene ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs Lou Withers

(Residence in Baltimore: No.

Honeyville Va

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH.

Monticello, 1836

(Month)

(Day)

(Year)

7-AGE.

49

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country).

Va

10-NAME OF FATHER.

Moses Self

11-BIRTHPLACE OF FATHER (State or Country).

Va

12-MAIDEN NAME OF MOTHER

Lucy Sydnor

13-BIRTHPLACE OF MOTHER (State or Country).

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Deceased

(Address)

Honeyville Va

15-

MAY 31 1915

HARRY O. ANDREWS,

Filed....., 191..

Serial Permit 01000

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

5-30-1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

5-24-1915, to 5-30-1915.

that I saw her alive on 5-30-1915.

and that death occurred, on the date stated above, at 1:05 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Uterine Fibroids

(Duration) 5 yrs. mos. ds.

(Signed) M. L. Hildreth M. D.

5-30-1915 (Address) University Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. 6 ds.

Where was disease contracted, if not at place of death? Honeyville Va

Former or usual residence Honeyville Va

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

Lodge Landing

....., 1915

20-UNDERTAKER

ADDRESS

William Cook

502 E. 5th

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85720

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Forland & Greene* ST.; *4* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *Albany N.Y.* St.; *4* yrs., *3* mos., *31* ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

37

yrs., mos., ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

N.Y.

10-NAME OF FATHER,

Palmer Cary

11-BIRTHPLACE OF FATHER (State or Country),

N.Y.

12-MAIDEN NAME OF MOTHER

Moulla Losse

13-BIRTHPLACE OF MOTHER (State or Country),

N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Deceased*(Address) *Gambello Md*

15-

MAY 31 1915

HARRY O. ANDREWS,

Filed..... 191... *Marial Permitt. Clay*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5-31-1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

5-5-1915 to *5-31-1915*,that I saw *her* alive on *5-31-1915*,and that death occurred, on the date stated above, at *12 noon*

The CAUSE OF DEATH* was as follows:

Edema of Lungs(Duration).....yrs.....mos.....*3* ds.

CONTRIBUTORY

(Secondary) *Streptococcus Septicemia*(Duration).....yrs.....mos.....*1 1/2* ds.(Signed) *M.H. Lichtenberg* M. D.*5-31-1915*, 1915. (Address) *University N.Y.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....*26* ds. In the State.....yrs.....mos.....*26* ds.Where was disease contracted, if not at place of death? *Albany N.Y.*Former or usual residence *Albany N.Y.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Albany N.Y. 5-31-1915

20-UNDERTAKER

ADDRESS

W.J. Tucker and Son

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85721

C85721

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: 30 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 1 - 1915
HARRY O. ANDERSON, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from May 8, 1915, to May 29, 1915,

that I saw him alive on May 28, 1915, and that death occurred, on the date stated above, at 8 9 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lung & throat
(Duration) 1 yrs. 4 mos. da.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) A. O. Decker, M. D.

May 28, 1915. (Address) 7600 Elm St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

C85722

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85722

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 S Carrollton Ave St. 18 WARD)2-FULL NAME Margaret Lawler(Residence in Baltimore: No. 10 S Carrollton Ave St.; — yrs., — mos., — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widowed
(Write the word.)

6-DATE OF BIRTH, Don't know, 1845
(Month) (Day) (Year)

7-AGE, 70 yrs., — mos., — ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Don't know

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Lawler

(Address) 110 S Carrollton Ave

15- HARRY O. ANDREWS,

Filed JUN 1 - 1915 1915 Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 29th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15 1915, to May 28 1915, that I saw h. alive on May 28 1915, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Older's Sclerosis
(Duration) 2 yrs., — mos., — ds.

CONTRIBUTORY (Secondary) Myocarditis

(Signed) E. C. Calver M. D.
May 29, 1915 (Address) 24 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral DATE OF BURIAL, June 1st 1915

20-UNDERTAKER John A. Moran & Son ADDRESS Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85723

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

41
REGISTERED No. C

C85723

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3017 Independent St. 9 WARD)

2 FULL NAME Carvel S. Mason

(Residence in Baltimore: No. 3017 Independent St. 75 yrs. 1 mos. 28 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH Apr 2, 1840
(Month) (Day) (Year)

7 AGE 75 yrs. 1 mos. 28 ds. or 1 day, 18 hrs. 18 min.?
If LESS than 1 day, hrs. min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Co. Md.

10 NAME OF FATHER George Mason

11 BIRTHPLACE OF FATHER (State or country) Balto Co. Md.

12 MAIDEN NAME OF MOTHER Catharine M. Mason

13 BIRTHPLACE OF MOTHER (State or country) Balto Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nesley H. Mason

(Address) 3017 Independent St.

15 JUN 1 - 1915 HARRY O. ANDREWS,

Barial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 30, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1, 1913, to May 28 1915, that I saw him alive on May 28, 1915, and that death occurred, on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH* was as follows:

Cancer of Rectum
(Clinical Diagnosis)
(Duration) 2 yrs. 1 mos. 30 ds.

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. J. Strickler, Jr. M. D.
May 30, 1915 (Address) 632 W. Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Woodlawn DATE OF BURIAL June 1, 1915

20 UNDERTAKER Miriam Cook ADDRESS 5026 North Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85724

CERTIFICATE OF DEATH

28

C85724

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. 9 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. 18 yrs. 10 mos. 8 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6-DATE OF BIRTH July 22, 1896 (Month) (Day) (Year)

7-AGE 18 yrs. 10 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) weigher Steam Bakery

9-BIRTHPLACE (State or country) Balto

10-NAME OF FATHER John C Eisel

11-BIRTHPLACE OF FATHER (State or country) Balto

12-MAIDEN NAME OF MOTHER Anna G. Rexroth

13-BIRTHPLACE OF MOTHER (State or country) Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

JUN 1 - 1915

HARRY O. ANDREWS,

Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Mac 30, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 4, 1915 to May 30, 1915, that I saw him alive on May 30, 1915, and that death occurred, on the date stated above, at 8 P.M. The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs (Duration) 4 yrs. 4 mos. 8 ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) H. J. Jones M. D. May 31, 1915 (Address) 1235th Lafayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL June 2, 1915

20-UNDERTAKER W. H. Cook ADDRESS 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85725

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85725

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. 17 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, X hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. JUN 1 - 1915

HARRY O. ANDREWS,
Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed), M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85726

C85726

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 665 Portland ST. 22 WARD)REGISTERED NO. C 31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Kelly(Residence in Baltimore: No. 665 Portland St.; 22 yrs., 1 mos., 3 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female4-COLOR OR RACE, White5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, April 28, 1886

(Month)

(Day)

(Year)

7-AGE, 29 yrs., 1 mos., 3 da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, William Kelly11-BIRTHPLACE OF FATHER (State or Country), Mass12-MAIDEN NAME OF MOTHER, Julia Beck13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Kelly(Address) 665 Portland Street

15-

Filed JUN 1 - 1915

191

HARRY O. ANDREWS,
Bureau of Health, City of Baltimore,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 31, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from September 9, 1914, to May 31, 1915, that I saw him alive on May 30, 1915, and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Intestines(Duration) 1 yrs., 1 mos., 3 da.CONTRIBUTORY Acute Endocarditis
(Secondary)(Duration) 7 yrs., 7 mos., 7 da.(Signed) J. M. Delaney M. D.May 31, 1915 (Address) 621 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 29 yrs., 1 mos., 3 da. In the State 29 yrs., 1 mos., 3 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, BaltimoreDATE OF BURIAL, June 1, 191520-UNDERTAKER, William BeckADDRESS, 522 E. 1st St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85727

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85727

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 14)

2-FULL NAME

(Residence in Baltimore: No. 316 S. Stricker

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 27 yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Aug. 25th, 1888

7-AGE,

27 yrs., 9 mos., - ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Md.

10-NAME OF FATHER,

Patrick Honohue

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Sobine Murphy

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Patrick Honohue

(Address)

316 S. Stricker

15-

Filed

JUN 1 - 1915

191

HARRY O. ANDREWS,

Baptist Minister, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 29th, 1915

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound of chest
Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism + Shock

(Duration) yrs. mos. ds.

(Signed) J. M. B. M. D.

May 30th, 1915. (Address) 2302 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the 28 yrs. mos. ds.

Where was disease contracted, if not at place of death? ...

316 S. Stricker St.

Former or usual residence 316 S. Stricker St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85728

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85728

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1524 E. Baltimore

FULL NAME

Bernard Smith

(Residence in Baltimore: No. 1524 E. Baltimore

St.:

WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St./yrs. 5 mos. 7 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

single

6-DATE OF BIRTH,

December 29, 1913

7-AGE,

1 yrs. 5 mos. 7 ds.

10 LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country).

Baltimore, Md.

10-NAME OF FATHER,

William Smith

11-BIRTHPLACE OF FATHER

(State or Country).

Md.

12-MAIDEN NAME OF MOTHER

Burke

13-BIRTHPLACE OF MOTHER

(State or Country).

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Elizabeth Brown

(Address)

1524 E. Fayette St.

JUN 1 - 1915

Filed

191. Serial Permit Office

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 31, 1915

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. M. D.

(Coroner.)

May 31, 1915 (Address) 1729 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS):

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Israel Cemetery

DATE OF BURIAL,

June 2, 1915

20-UNDERTAKER

Theodore White

ADDRESS

6702 2nd St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85729

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85729

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *7* WARD)2-FULL NAME *William Arnold*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No. *Hotel Baltimore N.Y.* St. *7* yrs. *40* mos. *1* da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *white* 5-SINGLE MARRIED *Married* WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH *September 17, 1960* (Month) (Day) (Year)

7-AGE *54* yrs. *8* mos. *14* ds. or *1* day, *8* hrs., *14* min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) *Retired*

9-BIRTHPLACE (State or country) *md.*

10-NAME OF FATHER *Abraham Arnold*

11-BIRTHPLACE OF FATHER (State or country) *Germany*

12-MAIDEN NAME OF MOTHER *Ellen Dennis*

13-BIRTHPLACE OF MOTHER (State or country) *Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *P. Phelps*(Address) *Johns Hopkins Hosp*

15-JUN 1 - 1915

Filed 191

HARRY O. ANDREWS,
Serial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 31, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr 21, 1915*, to, *May 31, 1915*, that I saw him alive on *May 31, 1915*, and that death occurred, on the date stated above, at *12:00 p.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(Diagnosis from sections of material removed at operation - no autopsy)

(Duration) *1* yrs. *40* mos. *1* ds.Contributory (SECONDARY) *Operation*(Duration) *1* yrs. *40* mos. *1* ds.

(Signed) *George R. Dunn* M.D.
May 31, 1915 [Address] *Johns Hopkins Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *40* yrs. *40* mos. *1* ds. In the *State* *✓* *✓*

Where was disease contracted, if not at place of death? *✓*

Former or usual residence *Hotel Baltimore, N.Y.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*London Park**June 2nd, 1915*

20-UNDERTAKER

ADDRESS

Newport in Long *W. J. Phillips*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85730

C85730

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1122 Shields alley* ST. *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Ellen Mitchell(Residence in Baltimore: No. *1122 Shields alley* St.: — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *female*4-COLOR OR RACE, *coloured*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

52

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Cook*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Frederick Maryland*10-NAME OF FATHER, *Daniel Mathew*11-BIRTHPLACE OF FATHER (State or Country), *Frederick MD*12-MAIDEN NAME OF MOTHER *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Frederick MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Chas T. Mitchell*(Address) *414 New St*

15-

JUN 1 - 1915.

HARRY O. ANDREWS,

Filed..... 191... *Serial. Permit. U.S.*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

(Month)

30

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 27* 1915, to *May 30* 1915, that I saw him alive on *May 30* 1915, and that death occurred, on the date stated above, at *10:15* p.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration).....

yrs.

mos.

ds.

CONTRIBUTORY (Secondary) *Heart Failure*

(Duration).....

yrs.

mos.

ds.

(Signed) *James A. Barr* M. D.*May 31* 1915. (Address) *737 Madison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....

yrs.

mos.

ds.

In the

State.....

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Peter's Cemetery.

DATE OF BURIAL,

June 2nd, 1915.

20-UNDERTAKER

Felix B. Pye

ADDRESS

102 E. Mulberry St.

N.B.—Every item of information should be carefully supplied. NOC should be written EXACTLY. PHYSICIAN'S SIGNATURE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85731

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1820 Byrd* ST.; *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1820 Byrd*St.; *35* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

75

yrs. mon. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

Godfried Schubring

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Schubring

(Address)

1820 Byrd St.

15-

JUN 1 - 1915

HARRY O. ANDREWS,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 30, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 23, 1915 to *May 30, 1915*that I saw him alive on *May 30, 1915*and that death occurred, on the date stated above, at *7 A. M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cardiac Action

(Duration) yrs. mos. ds.

(Signed) *R. D. Campbell* M. D.*May 30, 1915* (Address) *1644 Danvers*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Western Cemetery**June 1, 1915*

20-UNDERTAKER

R. D. Campbell

ADDRESS

1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85733

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85733

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (NO.

a-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *Jan*, 1907
(Month) (Day) (Year)

7-AGE, *8* *4* yrs. *4* mos. *4* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *School boy*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Frank Jowais*

11-BIRTHPLACE OF FATHER (State or Country), *Russia*

12-MAIDEN NAME OF MOTHER, *Hellie Zolenda*

13-BIRTHPLACE OF MOTHER (State or Country), *New York*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Jowais*

(Address) *628 Portland St.*

15- JUN 1 - 1915

Filed 191

BARRY O. ANDREWS

Marial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 29*, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *autopsy* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *autopsy* (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis
hemiplegia - struck by motor vehicle - falling head
(Duration) *2* yrs. *2* mos. *2* ds.

CONTRIBUTORY (Secondary) *Fractured Skull*

(Signed) *J. P. DePue* M. D.
(Address) *413 N. Carrollton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, *9* yrs. *9* mos. *9* ds. In the *8* yrs. *8* mos. *8* ds.

Where was disease contracted, if not at place of death? *633 Portland St.*

Former or usual residence *628 Portland*

19-PLACE OF BURIAL OR REMOVAL, *Holy Cross*

DATE OF BURIAL, *June 2 1915*

20-UNDERTAKER, *John Grebliaus*

ADDRESS *500 S. Beach*

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85734

C85734

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *24* WARD)2-FULL NAME *Nettie Strupp*(Residence in Baltimore: No. *1005 Compton St.* St.; — yrs., — mos., — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE. <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Married</i> (Write the word.)
6-DATE OF BIRTH. <i>Jan. 14, 1881</i> (Month) (Day) (Year)		
7-AGE. <i>34 yrs. 4 mos. 17 ds.</i>		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Housewife</i> (b) General nature of industry, business, or establishment in which employed (or employer). <i>General</i>		
9-BIRTHPLACE. (State or Country). <i>Md.</i>		
PARENTS.	10-NAME OF FATHER. <i>Charles Ways</i>	
	11-BIRTHPLACE OF FATHER. (State or Country). <i>Md.</i>	
	12-MAIDEN NAME OF MOTHER. <i>Alice McCluney</i>	
	13-BIRTHPLACE OF MOTHER. (State or Country). <i>Md.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mercy Hospital*(Address) *Calvert St.*

15-

JUN 1 - 1915

HARRY O. ARMSTRONG

Filed

Burial Permit - 0014
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 31, 1915*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr. 6, 1915*, to *May 31, 1915*, that I saw her alive on *May 31, 1915*, and that death occurred, on the date stated above, at *7:30 p.m.*

The CAUSE OF DEATH* was as follows:

Acute Parachymatous Nephritis
atmt (Duration).....yrs. *2* mos. *2* ds.

CONTRIBUTORY
(Secondary)

(Signed) *Edward L. Smith* M. D.
May 31, 1915 (Address) *Mary St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *25* ds. In the State *Life* yrs. mos. ds.

Where was disease contracted, if not at place of death? *1005 Compton St.*

Former or usual residence *1005 Compton St.*

19-PLACE OF BURIAL OR REMOVAL,

CEDAR HILL.

DATE OF BURIAL.

JUN 2 - 1915

20-UNDERTAKER

ARMSTRONG-DENNY CO.

ADDRESS

715 Light

16- Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE IS VERY IMPORTANT. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85735

C85735

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mon. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word.)

Married

6-DATE OF BIRTH

Oct 2

1848

(Month)

(Day)

(Year)

7-AGE

66

7

29

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Sail maker

9-BIRTHPLACE

(State or Country)

Norfolk Va

10-NAME OF FATHER

John V Gronewell

11-BIRTHPLACE OF FATHER

(State or Country)

Germany

12-MAIDEN NAME OF MOTHER

Mary V Davis

13-BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Emma J. Gronewell

(Address)

1002 William St

MEDICAL CERTIFICATE OF DEATH.

15-DATE OF DEATH

May 31, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 10 1915 to May 31 1915

that I saw him alive on May 31 1915

and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. 5 mon. ds.

CONTRIBUTORY (Secondary)

Pulmonary Edema

(Duration) yrs. 3 mon. ds.

(Signed)

May 31 1915 (Address) 1076 Mel St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

MOUNT OLIVET.

DATE OF BURIAL

JUN 2 - 1915

20-UNDERTAKER

ARMSTRONG-DENNY CO.

ADDRESS

715 Light

16-

JUN 1 - 1915

Filed

HARRY O. ANDREWS,
191. Burial Permit Clerk
Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85736

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85736

PLACE OF DEATH

CITY OF BALTIMORE (No. 2022 Payson St ST. 15 WARD)

2-FULL NAME William Lawrence O'Keefe

(Residence in Baltimore: No. 2022 Payson St St. 15 yrs. 2 mos. 2 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6-DATE OF BIRTH Jan 29, 1855
(Month) (Day) (Year)

7-AGE 60 yrs. 4 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ill.

10 NAME OF FATHER Thomas O'Keefe

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Ward

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Martha H. O'Keefe

(Address) 2022 1/2 Payson St.

15. JUN 1 - 1915 HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 31, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1915, to May 31, 1915, that I saw him alive on May 31, 1915, and that death occurred, on the date stated above, at 9:50 A.M.
The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach
(Clinical Diagnosis)

(Duration) yrs. 4 mos. 2 ds.
Contributory (SECONDARY) Exhaustion

(Signed) Chas. A. Fetherhoff, M.D.
May 31, 1915 (Address) 1807 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Wood Ridge Cemetery DATE OF BURIAL May 31, 1915

20-UNDERTAKER George J. Smith ADDRESS Payson St.

C85737

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85737

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *538 Robert* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *538 Robert St* St.; *31* yrs., — mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

May 25, 1884
(Month) (Day) (Year)

7-AGE,

31 yrs. — mos. *3* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

General Domestic

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

John W. Chambers

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Elizabeth Grant

13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Elizabeth Noel*(Address) *1433 McElderry St*

15-JUN 1 - 1915

HARRY O. ANDREWS,

Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 28 1915, to May 29 1915,*that I saw her alive on *May 28, 1915,*and that death occurred, on the date stated above, at *59* m.

The CAUSE OF DEATH* was as follows:

Typhoid fever
(Duration)..... yrs. *4* mos. *4* ds.

CONTRIBUTORY

(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *W. H. Robinson* M. D.*52910*, 1915 (Address) *61 N. Carroll St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel

DATE OF BURIAL,

June 1, 1915

20-UNDERTAKER

Robt A Elliott

ADDRESS

506 East St

1. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85738

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1102 Barclay* ST.; *10* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1102 Barclay* St.; *51* yrs., *2* mos., *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Married*

6-DATE OF BIRTH

March 17, 1864
(Month) (Day) (Year)

7-AGE,

51 yrs., *2* mos., *14* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Laborer*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*John Dyer*11-BIRTHPLACE OF FATHER
(State or Country),*Ireland*

12-MAIDEN NAME OF MOTHER

*Margt. McDermott*13-BIRTHPLACE OF MOTHER
(State or Country),*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Dyer*(Address) *1102 Barclay St.*

15-

JUN 1 - 1915

Marial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 31, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *May 31, 1915*, to *May 31, 1915*, that I saw him alive on *May 31, 1915*, and that death occurred, on the date stated above, at *330 P.m.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)*Oldema lungs*

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Bernard Weiss M. D.**5/31, 1915* (Address) *914 E. Biddle St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cathedral June 1, 1915

DATE OF BURIAL

20-UNDERTAKER

H. C. Wiedefeld 914 Greenmount

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85739

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85739

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3510 Park Heights Ave.* St.; *15th* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Bella D. Regester(Residence in Baltimore: No. *3510 Park Heights Ave.* St.; *2-5* yrs. *...* mos. *...* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH,

March 14, 1852
(Month) (Day) (Year)

7-AGE,

63 yrs. 2 mos. 16 ds.

IF LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *At home*
(b) General nature of industry, business, or establishment in which employed (or employer) *...*

9-BIRTHPLACE,

(State or Country), *Wheeling W. Va.*

10-NAME OF FATHER,

Alexander Graham

11-BIRTHPLACE OF FATHER

(State or Country), *Scotland*

12-MAIDEN NAME OF MOTHER

Ann Edmunds

13-BIRTHPLACE OF MOTHER

(State or Country), *Wales*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James W. Regester*(Address) *3510 Park Heights Ave.*

15-

JUN 1 - 1915

Filed

191

Serial Permit 0107

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 28, 1915, to *May 31, 1915*,that I saw her alive on *May 28, 1915*,and that death occurred, on the date stated above, at *8:30 p. m.*

The CAUSE OF DEATH* was as follows:

Strangled Umbilical Hernia(Duration) *...* yrs. *...* mos. *7* ds.

CONTRIBUTORY (Secondary)

(Duration) *...* yrs. *...* mos. *...* ds.(Signed) *James S. Ashmun, M. D.*
June 1, 1915 (Address) *4012 Park Heights Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *...* yrs. *...* mos. *...* ds. In the State *...* yrs. *...* mos. *...* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Lorraine Cemetery

DATE OF BURIAL,

June 2, 1915

20-UNDERTAKER

Henry W. Meas & Son

ADDRESS

805 N. Calvert St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85740

CERTIFICATE OF DEATH.

43
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1104 N. Monroe ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Estelle Redner(Residence in Baltimore: No. 1104 N. Monroe St.; 25 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

October 28th, 1875
(Month) (Day) (Year)

7-AGE,

39 yrs., 7 mos., 2 ds.If LESS than 1 day,
... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Housewife9-BIRTHPLACE,
(State or Country),Maryland

PARENTS.

10-NAME OF FATHER,

Ely Hibberd11-BIRTHPLACE OF FATHER
(State or Country),Maryland

12-MAIDEN NAME OF MOTHER

Mary Engler13-BIRTHPLACE OF MOTHER
(State or Country),Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr Wm. G. Redner

(Address)

1104 N. Monroe St

15-

JUN 1 - 1915

HARRY O. A. ...

Filed ... 1915 ...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 30, 1915
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 20 1915, to May 30 1915.that I saw him alive on May 20 1915, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma heart - operation
seen on top of heart - medical final
metastasis(Duration) 1 yrs., 6 mos., — ds.CONTRIBUTORY
(Secondary)(Duration) — yrs., — mos., — ds.(Signed) Thomas G. King, M.D.May 31, 1915 (Address) 325 N. Carroll St. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Landon Park CemeteryJune 2, 1915

20-UNDERTAKER

ADDRESS

Stewart Mowen Co10820 North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85741

C85741

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JUN 1 - 1915 ROBERT . KRAUTER,

Filed..... 191..... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

May 31 1915, to May 31 1915, that I saw her alive on May 31 1915, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Post-partum Hemorrhage

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....Labor (Chesent).....(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....J. M. Delerett.....M. D.

June 1, 1915 (Address).....621 Columbia Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill Cemetery June 2, 1915

20-UNDERTAKER

ADDRESS

E. Schloman Son Hannover

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *14* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1714 Madison Ave.* St.; *109* yrs., *0* mos., *0* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

unknown, 1885
(Month) (Day) (Year)

7-AGE,

30

If LESS than 1 day,

yrs. mos. ds.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *House Work*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country), *Maryland*10-NAME OF FATHER, *Harrison Robins*

11-BIRTHPLACE OF FATHER

(State or Country), *Ohio*12-MAIDEN NAME OF MOTHER, *Nancy Hill*

13-BIRTHPLACE OF MOTHER

(State or Country), *Ohio*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harrison Robins*(Address) *1714 Madison Ave.*

15-

Filed

JUN 1 - 1915

ROBERT J. KRAUTER

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 8, 1915, to *May 31*, 1915,that I saw her alive on *May 31*, 1915,and that death occurred, on the date stated above, at *2:15* p.

The CAUSE OF DEATH* was as follows:

Surgical Shock
(Duration) yrs. mos. ds. *3 hrs.*CONTRIBUTORY (Secondary) *Operation for**Internal Obstruction*
(Duration) yrs. mos. ds. *1*(Signed) *R. L. Johnson* M. D.*May 31*, 1915. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. *22* In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1714 Madison Ave.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Gruid Ridge Burial Ground, *June 1*, 1915.

20-UNDERTAKER

ADDRESS

Shofenkin Bros, *416 N. Charles St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085743

HEALTH DEPARTMENT—CITY OF BALTIMORE

151
085743

CERTIFICATE OF DEATH.

PLACE OF DEATH On lawn near tunnel of Penna. R.R.
CITY OF BALTIMORE (No. John st. near Wilson st. ST. 19 WARD)
FULL NAME Thomas Boyd,
(Residence in Baltimore: No. 304 Barclay Place.
St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Unknown,
6-DATE OF BIRTH, Unknown, /
(Month) (Day) (Year)
7-AGE, 28 ? yrs. ? mos. ? ds. If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Day laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Unknown,
10-NAME OF FATHER, Unknown,
11-BIRTHPLACE OF FATHER (State or Country), Unknown,
12-MAIDEN NAME OF MOTHER Unknown,
13-BIRTHPLACE OF MOTHER (State or Country), Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) No informant.
(Address)

15-JUN 1 - 1915 ROBERT KRAUTER,
Filed..... 191. Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 24th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Gunshot wound of heart,
(suicide)
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(Signed) J. Frederick Kumpel, M. D. (Coroner.)
May 25, 1915 (Address) 3310 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery
DATE OF BURIAL, June 15, 1915
20-UNDERTAKER, Geo. N. Holland
ADDRESS, 517 Robert St.

HEALTH DEPARTMENT—CITY OF BALTIMORE. C85744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2704 Elliott*ST. *1* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Michael Gontosz(Residence in Baltimore: No. *2704 Elliott St.*St. *3* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Not Known, 1887
(Month) (Day) (Year)

7-AGE,

28

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Labourer

(b) General nature of industry, business, or establishment in which employed (or employer).

Universal

9-BIRTHPLACE,

(State or Country),

Russia Poland

10-NAME OF FATHER,

Not Known

11-BIRTHPLACE OF FATHER

(State or Country),

Russia Poland

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Mary J. Gontosz

(Address)

2704 Elliott St.

15-

JUN 1 - 1915

ROBERT . KRAUTER,

Filed

191

Municipal Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 1, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

May 31 1915, to *June 1* 1915,that I saw him live on *May 31* 1915,and that death occurred, on the date stated above, at *5 a.m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lung

(Duration)

unknown

CONTRIBUTORY (Secondary)

(Duration)

myocarditis

(Signed)

A. B. Bittow M. D.*June 1*, 1915 (Address) *3035 Odessa*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSFERS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Stanislaus Cem.**June 2*, 1915

20-UNDERTAKER

ADDRESS

*Stephen J. Chalkowski**109 S. Henry St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *4* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in *Baltimore*: No. *Lafayette Md.* St.: yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, *Married*
(Write the word)6-DATE OF BIRTH, *June 10, 1887*
(Month) (Day) (Year)7-AGE, *68* yrs., *11* mos., *9* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer), *General*9-BIRTHPLACE, (State or Country), *Md.*PARENTS.
10-NAME OF FATHER, *Don't know*
11-BIRTHPLACE OF FATHER (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER, *Don't know*
13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anthony Winkler*(Address) *Lafayette Md.*15- *JUN 1 - 1915* ROBERT . KRAUTER, *Lafayette Md.*Filed 191... *Marial Permit Clerk* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 31, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 5, 1915*, to *May 31, 1915*, that I saw her alive on *May 31, 1915*, and that death occurred, on the date stated above, at *10:10* P.M.

The CAUSE OF DEATH* was as follows:

Chronic Paralytic Hepatitis and Endocarditis
(Duration) *Don't know*

CONTRIBUTORY (Secondary)

(Signed) *Edward J. Smith* M. D.
May 31, 1915 (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State *Lafayette* yrs., mos., ds.Where was disease contracted, if not at place of death? *Lafayette Md.*Former or usual residence *Lafayette Md.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Lafayette Md. *June 2, 1915*

20-UNDERTAKER

ADDRESS

J. Herwig & Co *2008 Blaine*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85746

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85746

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 E. Biddle ST.; 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1807 E. Biddle St.; 1 yrs., 6 mos., 6 da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH

Dec 25, 1834
(Month) (Day) (Year)

7-AGE

80 yrs., 6 mos., 6 da.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE, (State or Country),

Scotland

10-NAME OF FATHER

Jos. Sutherland

11-BIRTHPLACE OF FATHER (State or Country),

Scotland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. D. Simpson(Address) 1807 E. Biddle

JUN 1 - 1915

ROBERT KRAUTER,

Filed..... 191.. Mar 12.. Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1915, to May 31 1915,that I saw him alive on May 30 1915,and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Progressive Paralysis
(Duration) 3 yrs., 3 mos., 3 da.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs., 3 mos., 3 da.
(Signed) E. A. Smith M. D.
(Address) 1501 N. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 1 yrs., 3 mos., 3 da. In the State 1 yrs., 3 mos., 3 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt Holly Spring June 2 1915

20-UNDERTAKER

Philip Herwig Orleans ADDRESS 3016

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *120 W. Cross* REGISTERED NO. C
 CITY OF BALTIMORE: (No. *120 W. Cross* ST. *23* WARD) (If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)
 2-FULL NAME *Edith Horman*
 (Residence in Baltimore: No. *120 W. Cross* St. *3* yrs., *3* mos. *26* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)
 6-DATE OF BIRTH, *Feb 6, 1912* (Month) (Day) (Year)
 7-AGE, *3 yrs., 3 mos., 26 ds.* If LESS than 1 day, hrs. or min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, *none*
 (b) General nature of industry, business, or establishment in which employed (or employer).
 9-BIRTHPLACE, (State or Country), *Balto. Md.*
 10-NAME OF FATHER, *John H. Horman*
 11-BIRTHPLACE OF FATHER, (State or Country), *Md.*
 12-MAIDEN NAME OF MOTHER, *Cornellie Carneil*
 13-BIRTHPLACE OF MOTHER, (State or Country), *Mt. Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John H. Horman*
 (Address) *120 W. Cross St.*

15- *JUN 1 - 1915* ROBERT KRAUTER,
 Filed *1915* Burial Permit Clerk.
 Registrar.
9 a. m.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 1, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 28, 1915* to *June 1, 1915*, that I saw him alive on *June 1, 1915*, and that death occurred, on the date stated above, at *8:30 a. m.*
 The CAUSE OF DEATH* was as follows:
Scarlet Fever
 (Duration) yrs. mos. *4* ds.
 CONTRIBUTORY (Secondary) *Scarlet Fever*
 (Duration) yrs. mos. ds.
 (Signed) *W. M. L. Flynn* M. D.
June 1, 1915 (Address) *1215 E. Pratt*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park Cem.* DATE OF BURIAL, *June 2, 1915*

20-UNDERTAKER, *W. M. L. Flynn* ADDRESS, *1422 Light St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85748 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 715 W Lafayette Ave ST. 17 WARD)

2-FULL NAME Hamilton Marbury Brewer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 715 W Lafayette Ave St. 54 yrs. 2 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6-DATE OF BIRTH March 4, 1861
(Month) (Day) (Year)

7-AGE 54 yrs. 2 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Real Estate Business
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore, Md

10-NAME OF FATHER Geo. B. Brewer

11-BIRTHPLACE OF FATHER (State or country) Anne Arundel Co. Md

12-MAIDEN NAME OF MOTHER Matilda Marbury

13-BIRTHPLACE OF MOTHER (State or country) District of Columbia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Meta F Brewer

(Address) 715 W Lafayette Ave

15. JUN 1 - 1915. ROBERT K. BRAUTER, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 31, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4th, 1915, to May 30, 1915.

that I saw him alive on May 30, 1915, and that death occurred, on the date stated above, at 3:40 p. m.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis

unknown (Duration) yrs. mos. ds.

Contributory Indefinite (SECONDARY) (Duration) yrs. mos. ds.

(Signed) H. K. Arthur M. D. May 31, 1915 (Address) 1426 W Kenwood St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL June 2, 1915

20-UNDERTAKER Geo W Little ADDRESS 531 N Diamond Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85749

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85749

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

940 W. Franklin

ST: 18

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Geo. W. Frick

(Residence in Baltimore: No.

940 W Franklin

St.: 23 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH

Dec 24 1891 (Month) (Day) (Year)

7-AGE

23 yrs. 5 mos. 6 ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Clerk

9-BIRTHPLACE

(State or country)

Baltimore Md

PARENTS

10-NAME OF FATHER

Isaiah D. Frick

11-BIRTHPLACE OF FATHER

(State or country)

Penn.

12-MAIDEN NAME OF MOTHER

Alice C. Jones

13-BIRTHPLACE OF MOTHER

(State or country)

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

I. D. Frick

(Address)

940 W Franklin

15-

JUN 1 - 1915

ROBERT KRAUTER,

Serial Permit Clerk,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 31, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 2, 1915, to May 31, 1915.

that I saw him alive on May 31, 1915.

and that death occurred, on the date stated above, at 104 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

(Duration) 1 yrs. 6 mos. — ds

Contributory (SECONDARY)

(Duration) 11 yrs. 6 mos. — ds

(Signed)

6/1/15

(Address)

Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Londont Park

DATE OF BURIAL

June 3, 1915

20-UNDERTAKER

Geo W Little

ADDRESS

531 Fremont Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85-50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1308 Harford Ave 9*)

2-FULL NAME

(Residence in Baltimore: No. *1308 Harford Ave*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *73* yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

Oct 19

(Month)

(Day)

(Year)

7-AGE

*73**7**12*

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Fireman**Balti Dept*

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

James Wiley

11-BIRTHPLACE OF FATHER (State or Country),

md

12-MAIDEN NAME OF MOTHER

Elnora Witzel

13-BIRTHPLACE OF MOTHER (State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary E. Wiley

(Address)

1308 Harford Ave

15-

JUN 1 - 1915

Filed, 191

ROBERT A. BREWSTER,

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *January 3* 1915, to *June 1* 1915, that I saw him alive on *May 31* 1915, and that death occurred, on the date stated above, at *7 a* m. The CAUSE OF DEATH* was as follows:*Chronic Nephritis*

(Duration)

18

yrs., mos., da.

CONTRIBUTORY (Secondary)

(Duration)

1

yrs., mos., da.

(Signed)

Hubert C. L. ...

M. D.

June 1., 1915. (Address) ... 1216 E. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs., mos., da.

In the

State

yrs., mos., da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

20-UNDERTAKER

DATE OF BURIAL,

June 3., 1915

ADDRESS

502 W. North

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificate.

C85-51

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

122 C85-51

PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 ST. 16 WARD)

2-FULL NAME James Summerville

(Residence in Baltimore: No. 1108 Woodley St. City St.; — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RU on No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX <u>Male</u>	4-COLOR OR RACE <u>White</u>	5-SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH <u>Nov</u> <u>21</u> , 19 <u>53</u> (Month) (Day) (Year)		
7-AGE <u>6</u> yrs. <u>6</u> mos. <u>10</u> ds. or min.?		If LESS than 1 day, hrs.
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Painter</u>		

9-BIRTHPLACE
(State or country)

PARENTS	10-NAME OF FATHER <u>Thos. Summerville</u>
	11-BIRTHPLACE OF FATHER (State or country) <u>Md.</u>
	12-MAIDEN NAME OF MOTHER <u>Eddy Engels</u>
	13-BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur
(Address) 1108 Woodley St. City

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
May 31, 1955
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
Apr 26, 1955, to, May 31, 1955,
that I saw him alive on May 31, 1955,
and that death occurred, on the date stated above, at 5:15 P.

The CAUSE OF DEATH* was as follows:

Chronic Pyelonephritis

Contributory
(SECONDARY)

(Duration) about 5 yrs. mos. ds.
Arteriosclerosis
(Signed) William J. H. H. H. M. D.
May 31, 1955 [Address] 1108 Woodley St. City

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. 35 ds. In the 6 yrs. 6 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1108 Woodley St. City

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Oliver June 2, 1955
20-UNDERTAKER ADDRESS Harry W. Chley, W. North Ave.

JUN 2 - 1955

Filed 1955 HARRY O. ANDREWS, REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085-52

HEALTH DEPARTMENT—CITY OF BALTIMORE

085-52

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *509 S. Callington Ave.* ST. *1*)

WARD)

FULL NAME *Infant Robert*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *509 S. Callington Ave.*

St.: yrs. *23* mos. *hrs.* *da.*

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

May 30, 1915
(Month) (Day) (Year)

7-AGE,

23 yrs. 23 mos. 23 hrs.

If LESS than 1 day,

23 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Charles D. Roberts

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Helen Donovan

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Helen Roberts*

(Address) *509 S. Callington Ave.*

15-

Filed

JUN 2 - 1915

HARRY O. ANDREWS,

191. *Burial Permit* *0191*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. J. Jones* M. D.
(Coroner)

June 1, 1915 (Address) *3116 O'Donnell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer

June 2, 1915

20-UNDERTAKER,

ADDRESS

William Ziayowski

1618 Eastern Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1121 Briscoe*)ST.; *21* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Audrey Marie Warner*(Residence in Baltimore: No. *1107 Russell*)St.; yrs. *3* mos. *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

February 13, 1915
(Month) (Day) (Year)

7-AGE,

yrs. *3* mos. *18* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Infant*9-BIRTHPLACE,
(State or Country).*Baltimore Md.*

10-NAME OF FATHER,

*Ernest Warner*11-BIRTHPLACE OF FATHER
(State or Country).*Baltimore Md.*

12-MAIDEN NAME OF MOTHER

*Martha Estella Hays*13-BIRTHPLACE OF MOTHER
(State or Country).*Baltimore Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph Hays*(Address) *1146 Russell St.*

15-JUN 2 - 1915

HARRY O. ANDREWS,

Filed..... 191... *Burial Permit Only*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 30, 1915, to *May 31, 1915*,that I saw her alive on *May 30, 1915*,and that death occurred, on the date stated above, at *9 P.* m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(Duration)..... yrs..... mos. *4* ds.CONTRIBUTORY *Inanition*
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *J. L. Smith* M. D.*May 1, 1915* (Address) *645 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Mt. Zion Am.**June 2, 1915*

20-UNDERTAKER

ADDRESS

*John H. Trادين**142 W. Hill St*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85754

41

C85754

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *110 Rochester Place* ST.; *1* WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Veronica Schmidt
(Residence in Baltimore: No. *110 Rochester Place* St.; *69* yrs., *1* mos., *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, *Widowed*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Feb. 25th, 1838
(Month) (Day) (Year)

7-AGE,

*77 yrs., 3 mos., 6 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

*Henry Hoor*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Not Known*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Emma Adolph*(Address) *110 Rochester Place*

15-

JUN 2 - 1915

HARRY O. ANDREWS,

Filed..... 191... *Burial Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*April 2, 1915, to May 31, 1915,*that I saw her alive on *May 31, 1915,*and that death occurred, on the date stated above, at *6 P. m.*

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Intestines
(Duration) *1* yrs. *1* mos. *1* ds.CONTRIBUTORY
(Secondary)(Signed) *Wm. H. Insley* M. D.
June 1, 1915 (Address) *2938 E. Pratt*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mount Carmel

DATE OF BURIAL,

June 3, 1915

20-UNDERTAKER

H. Sander Sons

ADDRESS

110 Rochester

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

C85755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 REGISTERED NO. C85755

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2512 Penna Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia A Leach
(Residence in Baltimore: No. 2512 Penna Ave St.; 78 yrs. 8 mos. 20 da)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, French 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Sept 12th, 1836
(Month) (Day) (Year)

7-AGE, 78 yrs. 8 mos. 20 da. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), City

10-NAME OF FATHER, John P. Poole

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Hannah Elliott

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Maggie Horatzen
(Address) 2512 Penna Ave

15-Filed JUN 2 - 1915 HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1st, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr-1- 1915, to June-1- 1915, that I saw her alive on June-1- 1915, and that death occurred, on the date stated above, at 8 a m. The CAUSE OF DEATH* was as follows:

Exhaustion
(Duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Exhaustion
(Duration) yrs. mos. da.

(Signed) Martin A. Shock M. D.
June 1, 1915 (Address) 806 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VICARIOUS CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

London Va June 3, 1915

20-UNDERTAKER, ADDRESS, J. J. Walker 223 W. 2nd

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2628 E. Hoffman* ST.; *8* WARD)2-FULL NAME *Mary E. Hoffman*(Residence in Baltimore: No. *2628 E. Hoffman* St.; *8* WARD)REGISTERED NO. C *85756*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *8* WARD, mos. (da)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Widow*

6-DATE OF BIRTH,

May 1st, 1848
(Month) (Day) (Year)

7-AGE,

67 yrs. — *30* mos. — *30* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housewife*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

John A. Kerner

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Anna Fischer

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. David Cordle*(Address) *2628 E. Hoffman*

15-

JUN 2 - 1915

HARRY O. ANDREWS,

Filed

191

Serial 2011101

Registrar.

is a wife

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *May 31, 1915* to *May 31, 1915*that I saw him alive on *May 30, 1915*, and that death occurred, on the date stated above, at *6 P.M.*

The CAUSE OF DEATH* was as follows:

*(Clinical diagnosis)
Rupture of uterus
infection of blood*CONTRIBUTORY
(Secondary)(Duration) *7* yrs. — *1* mos. — *1* ds.(Signed) *Arthur Wright**June 1, 1915* (Address) *2050 E. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *7* yrs. — *1* mos. — *1* ds. In the State *7* yrs. — *1* mos. — *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Church

DATE OF BURIAL,

June 1, 1915

20-UNDERTAKER

Ed Walker

ADDRESS

723 Arden

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 225 S. Chapel ST.: 2 WARD) REGISTERED NO. C 85757
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
FULL NAME Alice Beatty
(Residence in Baltimore: No. 225 S. Chapel St. St.: yrs. Life ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married
6-DATE OF BIRTH, August 13, 1873 (Month) (Day) (Year)
7-AGE, 41 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or ...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work... Housework (b) General nature of industry, business, or establishment in which employed (or employer)... At home
9-BIRTHPLACE, (State or Country), Baltimore
PARENTS.
10-NAME OF FATHER, Thomas Phillips
11-BIRTHPLACE OF FATHER (State or Country), Not known
12-MAIDEN NAME OF MOTHER, Susan Gough
13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J. Beatty
(Address) 225 S. Chapel St.

15- JUN 2 - 1915 HARRY O. ANDREWS, Registrar.
Filed... 191... Burial... PARRIS OLORE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1st, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy of inquiry.) thereon and from the evidence obtained by said inquest, autopsy of inquiry, and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds.

Signed, J. W. Jones, M. D. (Coroner)
June 1, 1915 (Address) 3116 Agnew St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cent June 4, 1915
20-UNDERTAKER, Roll S. Turner 1422 N. Bridge St. ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

085758

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* St. *5* WARD)

2 FULL NAME

(Residence in Baltimore: No. *643 Sterling St* St. *7* yrs. *7* mos. *3* ds.)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female Colored

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

Oct. 27, 1914

(Month)

(Day)

(Year)

7-AGE

7

3

If LESS than
1 day, hrs.
..... yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

md. Balto City

10-NAME OF FATHER

Joseph Tate

11-BIRTHPLACE OF FATHER
(State or country)

md.

12-MAIDEN NAME OF MOTHER

Mary Snowden

13-BIRTHPLACE OF MOTHER
(State or country)

md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *P. Phelp*

(Address) *Johns Hopkins Hosp*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 1, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from
May 5, 1915 to *June 1, 1915*

that I saw *her* alive on *June 1, 1915*,
and that death occurred, on the date stated above, at *3:10 p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)

2

mos.

ds.

Contributory
(SECONDARY)

(Duration)

1

mos.

ds.

(Signed)

Anna S. Roth

June 1, 1915

(Address)

Johns Hopkins Hosp

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

6

mos.

ds.

In the

✓

State

✓

ys.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

643 Sterling St.

19-PLACE OF BURIAL OR REMOVAL

Ashery Cemetery

DATE OF BURIAL

June 3, 1915

20-UNDERTAKER

ADDRESS

R. E. Gross 1405 Maryland

JUN 2 - 1915

HARRY O. ANDREWS,

FILE

191

Burial Permit Office

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85759

CERTIFICATE OF DEATH

105 C85759

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *426 N. Caroline* ST. *5* WARD)FULL NAME *Mary F. Saunders*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

(Residence in Baltimore: No. *426 N. Caroline* St. *40* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

*Celoid*5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED*Married*
(Write the word)

6-DATE OF BIRTH

Unknown, 1

(Month)

(Day)

(Year)

7-AGE

48

yrs.

mos.

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*cook*

9-BIRTHPLACE

(State or country)

md

10-NAME OF FATHER

*Wm. Fisher*11-BIRTHPLACE OF FATHER
(State or country)*md*

12-MAIDEN NAME OF MOTHER

*Kones*13-BIRTHPLACE OF MOTHER
(State or country)*md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. Saunders

(Address)

426 N. Caroline St.

JUN 2 - 1915

HARRY O. ANDREWS,

Filed

191

Burial Permit No. *1405*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 1st, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 12th, 1915, to *June 1st*, 1915.that I saw him alive on *May 31st*, 1915.and that death occurred, on the date stated above, at *10:55 a* m.

The CAUSE OF DEATH* was as follows:

Gastritis(Duration) yrs. *0* mos. *22* ds.Contributory
(SECONDARY)*Asthma*(Duration) yrs. *2* mos. *2* ds.

(Signed),

*Samuel J. ... M. D.**June 2nd*, 1915.(Address) *1516 20th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

mt Auburn cemetery June 6, 1915

20-UNDERTAKER

ADDRESS

R. E. Cross 1405 Maryland St.

721 E. ... HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 685760
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 742 N. E. ... ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 742 N. E. ... St.; ... yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE. white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. widow
(Write the word.)
6-DATE OF BIRTH. Unknown, 1855
(Month) (Day) (Year)

7-AGE. 60 yrs., ... mos., ... ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 2 - 1915

HARRY O. ANDREWS,

BAPTIST CHURCH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 9, 1915, to June 1, 1915, that I saw her alive on May 31, 1915, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) 2 yrs., ... mos., ... ds.

CONTRIBUTORY (Secondary)

(Signed) George L. ... M. D.
June 1, 1915 (Address) 721 N. E. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

St. Mary's ... June 3, 1915.

20-UNDERTAKER

ADDRESS

McFahy & Sons 606 Fayette St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182

C85761

PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Josephs Hosp.* ST. *9* WARD)

2-FULL NAME *Charles Bowling*

(Residence in Baltimore: No. *Unknown* St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*

4-COLOR OR RACE, *Colored*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Unknown*

6-DATE OF BIRTH, *Unknown*, 1 (Month) (Day) (Year)

7-AGE, *26* yrs., mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Unknown*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hamilton Bouldin*

(Address) *Sutland St. Virginia*

15-

Filed *June 2, 1915*

ROBERT KRAUTER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 28, 1915* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burn Shot Wound (Homicide)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Chas. H. Russell* M. D. (Coroner.)

May 31, 1915 (Address) *1123 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Id.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Southland Station June 3, 1915*

20-UNDERTAKER

Wm. J. G. Jackson 1409 Mullett St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

05762

x 26

05762

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. W. I. WARD)

2-FULL NAME

Alexander C. Daile

(If death occurred in a hospital or institution, give its NAME instead of street and number and file cut No. 18.)

(Residence in Baltimore: No.

"Snow Hill, N. C."

St; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

6-DATE OF BIRTH

Unknown

11859

(Month)

(Day)

(Year)

7-AGE

56

yrs.

mos.

ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9-BIRTHPLACE

(State or country)

North Carolina

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER

(State or country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. B. Thompson

(Address)

Johns Hopkins Hosp.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June second, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1, 1915, to, June 2, 1915,

that I saw him alive on June 1, 1915,

and that death occurred, on the date stated above, at 12:10 A.M.

The CAUSE OF DEATH* was as follows:

Pellagra

(Duration)

5 yrs.

mos.

ds.

Contributory
(SECONDARY)

meningitis

(Duration)

0 yrs.

mos.

3 ds.

(Signed),

C. B. Thompson

M. D.

June 2, 1915 [Address] Johns Hopkins Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

1

mos.

8

ds.

In the

State

yrs.

1

mos.

8

ds.

Where was disease contracted, if not at place of death?

Snow Hill, N. C.

Former or usual residence

Snow Hill, N. C.

19-PLACE OF BURIAL OR REMOVAL

Farmville N. C.

DATE OF BURIAL

June 3, 1915

20-UNDERTAKER

Walter E. Fuller

ADDRESS

221 N. Broadway

JUN 2 - 1915

Filed

ROBERT K. KRAUTH

Official Permit

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85763

C85763

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (NO.

2-FULL NAME

(Residence in Baltimore: No.

Mercy Hospital
Ada R. Jacobs
2218 Christian St.

ST.

WARD

20

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

7-AGE.

IF LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

JUN 2 - 1915.

ROBERT . KRAUTH,

Filed..... 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Shock and Internal Hemorrhage
the result of being accidentally
struck by an automobile
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed)

James M. Savage M. D.
(Coroner.)
June 1, 1915 (Address) 1724 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bedar Hill Cemetery

June 3, 1915

20-UNDERTAKER

ADDRESS

Mrs A Rhodeson

730 Park Ave

685764

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 685764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 S. Durham ST.; V WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Christina Schellenberger(Residence in Baltimore: No. 12 S. Durham St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED, Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

Sept 6, 1886
(Month) (Day) (Year)

7-AGE.

78 yrs., 8 mos., 25 ds.If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework9-BIRTHPLACE,
(State or Country),Germany

10-NAME OF FATHER,

Weinefeld11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rudolph Schellenberger(Address) 12 S. Durham St.

15-

JUN 2 - 1915 ROBERT KRAUTER,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
May 28, 1915, to May 31, 1915,
that I saw him alive on May 30, 1915,
and that death occurred, on the date stated above, at 1:25 p.m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration)..... yrs..... mos..... 3 ds.
CONTRIBUTORY.....
(Secondary).....
(Duration)..... yrs..... mos..... ds.
(Signed) E. P. Whitton M. D.
June 2, 1915. (Address) 1711 E. Bait St.
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence.....
19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,
St. Alphonsus Cem. June 3, 1915.
20-UNDERTAKER ADDRESS
Lilly & Zeiler 4038 Wolfe

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1925 G. Balto. ST.; V WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

2-FULL NAME Bernadina Busse(Residence in Baltimore: No. 1925 G. Balto. St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. widow
(Write the word.)

6-DATE OF BIRTH. Feb. 2nd, 1833
(Month) (Day) (Year)

7-AGE. 82 yrs., 3 mos., 30 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country), Germany

10-NAME OF FATHER, Henry H. Thoman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Belvelage

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Mamie Busse(Address) 1925 G. Balto. St.

15-

JUN 2 - 1915

ROBERT KRAUTER,

City Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1915, to June 1 1915, that I saw him alive on June 1 1915, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Senile Dropsy - Pneumonia

(Duration).....yrs. 1 mos.ds.

CONTRIBUTORY (Secondary) Coronary Sclerosis

(Duration).....yrs.mos. 5 ds.

(Signed) M. D.

June 2, 1915. (Address) 125 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

Holy Redeemer

DATE OF BURIAL,

June 5, 1915.

20-UNDERTAKER

Lilly Zeiler

ADDRESS

403 S. Wolfe St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4108 Fernhill Ave.* ST. *15* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *4108 Fernhill Ave.* St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, *Married*,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Sept 7, 1891
(Month) (Day) (Year)

7-AGE

38 yrs. *8* mos. *26* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Chicago, Ill.*10-NAME OF
FATHER,*Charles Randolph*11-BIRTHPLACE
OF FATHER
(State or Country),*Ill.*12-MAIDEN NAME
OF MOTHER*Eliza Lane*13-BIRTHPLACE
OF MOTHER
(State or Country),*Ireland.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

JUN 2 - 1915

Filed..... 191.....

ROBERT . KRAUTH,

Serial Permit Officer
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 2, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
May 17 1915, to *June 2* 1915,
that I saw h- alive on *June 2* 1915,
and that death occurred, on the date stated above, at *38* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(Duration)..... yrs. *1* mos. — ds.CONTRIBUTORY
(Secondary)*Paralysis + Heart
Disease* (Duration)..... yrs. — mos. *5* ds.
(Signed)..... *Ben S. Wells*..... M. D.
June 2, 1915 (Address)..... *Baltimore**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. — mos. — ds. In the State..... yrs. — mos. — ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Chicago, Ill.

DATE OF BURIAL,

June 8, 1915

20-UNDERTAKER

Wm. M. Gault

ADDRESS

*624 N. 5th**Royal Ave*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85767

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 C85767

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *991 Shuter*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME *Saura Bodley*

ST. *7* WARD

(Residence in Baltimore: No. *901 Shuter*)

St. *—* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*
(Write the word)

6 DATE OF BIRTH *March 5, 1861*
(Month) (Day) (Year)

7 AGE *54* yrs. *2* mos. *28* ds. or min. *2* If LESS than 1 day, hrs.

8 OCCUPATION *House Wife*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Kent Co Md*

PARENTS

10 NAME OF FATHER *Wm Weber*

11 BIRTHPLACE OF FATHER (State or country) *Kent Co*

12 MAIDEN NAME OF MOTHER *Not known*

13 BIRTHPLACE OF MOTHER (State or country) *Kent Co*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Anna Bodley*

(Address) *901 Shuter St*

15 *3 - 1915*

HARRY O. ANDREWS,

Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *June 1, 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *May 29, 1915* to *June 1, 1915*, that I saw her alive on *June 1, 1915* and that death occurred, on the date stated above, at *11:37* pm. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Paralysis
(Duration) yrs. *3* mos. *3* ds.

Contributory (SECONDARY) *le or na*
(Duration) yrs. *3* mos. *3* ds.

(Signed) *Rev J E Ag* M. D.
6/2, 1915 (Address) *7094 Bodway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85768

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

154 C85768

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *808 Columbia E* ST. *71* WARD)

FULL NAME *Sarah V. Biddison*

(Residence in Baltimore: No. *808 Columbia E* St. yrs. mos. ds.)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. MARRIAGE *Widowed*
(Write the word)

6. DATE OF BIRTH *Sept 1, 1859*
(Month) (Day) (Year)

7. AGE *about 56* yrs. mos. ds. or min.?
If LESS than 1 day, hrs.

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Home Work

9. BIRTHPLACE (State or country)

Balto

10. NAME OF FATHER

Loft/Kuo

11. BIRTHPLACE OF FATHER (State or country)

Balto

12. MAIDEN NAME OF MOTHER

Loft/Kuo

13. BIRTHPLACE OF MOTHER (State or country)

Balto

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary G. Leans-

(Address)

521 Wyeth St

JUN 3 - 1915

HARRY O. ANDREWS,

Filed

191

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10. DATE OF DEATH

Jan 1, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 15, 1915, to Jan 1, 1915,

that I saw her alive on *May 31, 1915,*

and that death occurred, on the date stated above, at *2:30* m.

The CAUSE OF DEATH* was as follows:

Senility
Complicated by Pulmonary Embolism

(Duration) *1* yrs. mos. ds.

Contributory (SECONDARY)

Exhaustion

(Duration) *1* yrs. mos. ds.

(Signed)

Samuel H. Hogg

M. D.

Jan 1, 1915 (Address) *729 E. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

W. Eastern Cem

6/3/1915

20. UNDERTAKER

ADDRESS

William York

3076 N. York

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85769

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85769

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1905 Eting St. 14 WARD)

2-FULL NAME Elizabeth Burke

(Residence in Baltimore: No. 1905 Eting St. - yrs. - mos. - ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and R. out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE Colored 5-SINGLE MARRIED WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH Ant. Know 18 (Month) (Day) (Year)

7-AGE 54 If LESS than 1 day, hrs., yrs. mos. ds. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work Home work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Columb Co Md

10-NAME OF FATHER Joshua Morrell 11-BIRTHPLACE OF FATHER Columb Co Md 12-MAIDEN NAME OF MOTHER Eliza grass 13-BIRTHPLACE OF MOTHER Columb Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Morrell (Address) 1905 Eting St

15- JUN 3 - 1915

HARRY O. ANDREWS,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 2, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 9, 1915, to June 2, 1915, that I saw her alive on June 1, 1915, and that death occurred, on the date stated above, at 6 A. M. The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (Duration) yrs. 2 mos. ds.

Contributory (SECONDARY) H. S. M. Leach (Signed) June 2, 1915 (Address) 2005 Eting St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Plum Port Columb Co DATE OF BURIAL June 5, 1915

20-UNDERTAKER John H. O'Brien ADDRESS 1222 Eving St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85770

C85770

CERTIFICATE OF DEATH.

29
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE; (NO.

ST.; 23 WARD)

FULL NAME

(Residence in Baltimore; No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX.

4-COLOR OR RACE.

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

Write the word.

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 3 - 1915

HARRY O. ANDREWS,

Serial Forensic Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 17 1915, to May 30 1915,

that I saw him alive on May 30 1915,

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

about (Duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY
(Secondary)(Signed) Edward J. Smith M. D.
May 30 1915 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 13 mos. 13 ds. In the State 13 yrs. 13 mos. 13 ds.

Where was disease contracted, if not at place of death? 206 W. Green St.

Former or usual residence 206 W. Green St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Mt Auburn June 3, 1915.

20-UNDERTAKER

ADDRESS

L. H. Brown & Son 18 W. Montz St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85771

C85771

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N. Wolfe

ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. 18 N. Wolfe

St.: 8 yrs., 5 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.)

6-DATE OF BIRTH.

June 22nd, 1855
(Month) (Day) (Year)

7-AGE.

60 yrs. - mos. - ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Florist
Universal9-BIRTHPLACE,
(State or Country),

Washington D.C.

10-NAME OF FATHER,

John Davison

11-BIRTHPLACE OF FATHER

(State or Country),

England

12-MAIDEN NAME OF MOTHER

Maria L. Lane

13-BIRTHPLACE OF MOTHER

(State or Country),

D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Mary E. Davison

(Address).....

3004 Fairview Ave

JUN 3 - 1915

Filed.....

191

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HARRY O. ANDREWS,

Baltimore, Md.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 2nd, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 10 1915, to May 27th 1915, that I saw him alive on May 27th 1915, and that death occurred, on the date stated above, at 11⁴⁰A.m.

The CAUSE OF DEATH* was as follows:

Laryngeal tuberculosis
Chronic
(Duration) yrs. 2 mos. - ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. 3 mos. - ds.

(Signed) Anderson S. Owen, M.D.

June 2nd, 1915. (Address) 214 D St. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mr Oliver Washg D.C. June 3 1915

20-UNDERTAKER

ADDRESS

Mendell Lippel Rm 37 Ave m.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85772

C85772

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *18 N Port* ST.; *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *18 N Port* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Infant*

6-DATE OF BIRTH.

March 31, 1915
(Month) (Day) (Year)

7-AGE,

2 mos. 1 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Infant*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country), *Baltimore*

10-NAME OF FATHER,

Harry C. Winhelman

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Anna C. Utz

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry C. Winhelman*(Address) *18 N Port*

15-JUN 3 - 1915

Filed..... 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

April 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 30 191, to *June 1* 191that I saw h... alive on *June 1* 191and that death occurred, on the date stated above, at *25 p.m.*

The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs..... mos..... ds.
(Signed)..... M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Holy Redeemer**April 3, 1915*

20-UNDERTAKER

ADDRESS

Wendell Pappalardo 378 mm

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85773

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *817 S Luzerne* ST.; *1* WARD)

FULL NAME

(Residence in Baltimore: No.

Regina Lubinska
817 S Luzerne

St.; yrs. mos. ds)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE

Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

*Feb**8**1915*

(Month)

(Day)

(Year)

7-AGE,

*3**25*

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*Jim Lubinski*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore*

12-MAIDEN NAME OF MOTHER

*Boleslawa Smith*13-BIRTHPLACE OF MOTHER
(State or Country),*Rusia Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Boleslawa Lubinska

(Address).

817 S Luzerne St

JUN 3 - 1915

Filed..... 191

HARRY O. ANDREWS,

Merial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*June**2**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 23 1915, to *June 2* 1915,that I saw her alive on *June 2* 1915,and that death occurred, on the date stated above, at *3 p.* m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration)

yrs.

*No known*CONTRIBUTORY
(Secondary)*Edema of lungs*

(Duration)

yrs.

Can. 2 ds.

(Signed)

Dr. Januszko

M. D.

June 3 1915. (Address) *2431 East Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St Stanislaus Cem**June 3, 1915*

20-UNDERTAKER

ADDRESS

Stephen Fialkowski

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85774

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *London & Madison St* ST.: *45* WARD)

REGISTERED NO. C85774

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *2932 Clifton Ave.* St.: *2* yrs. *2* mos. *16* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH

March 17, 1913
(Month) (Day) (Year)

7-AGE

2 yrs. 2 mos. 16 ds.

IF LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or Country)

Baltimore

10-NAME OF FATHER

Henry W. Peters

11-BIRTHPLACE OF FATHER

(State or Country)

Va.

12-MAIDEN NAME OF MOTHER

Eva K. Sullivan

13-BIRTHPLACE OF MOTHER

(State or Country)

W.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

JUN 3 - 1915

HARRY O. ANDREWS,

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 2, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

*May 22, 1915, to June 2, 1915,*that I saw him alive on *June 2, 1915,*and that death occurred, on the date stated above, at *5:40 a.m.*

The CAUSE OF DEATH was as follows:

Heart Failure, Kidney...
removal of operation(Duration)..... yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

Also Colitis
(Signed)..... *J. Earle Hull* M. D.*June 2, 1915* (Address) *2932 Clifton Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State *2* yrs. *2* mos. *16* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

2932 Clifton Ave

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Cemetery, June 3, 1915

20-UNDERTAKER

ADDRESS

George J. Smith, 1932 Clifton Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *2401 Eager Place*)ST.: *7*

WARD)

FULL NAME *Charles Kittlein*Residence in Baltimore: No. *2401 Eager Place*

St.: yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR, OR RACE, *White* 5-SINGLE, MARRIED, WIDOW, OR DIVORCED, *Married*
(Write the word.)

6-DATE OF BIRTH, *April 1, 1866*
(Month) (Day) (Year)

7-AGE, *49* yrs. *2* mos. *0* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Tailor*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *MD*

10-NAME OF FATHER, *Michael Kittlein*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Minnie Kittlein*

(Address) *2401 Eager Pl.*

15- *JUN 3 - 1915* HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 1, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*
(Inquest, autopsy or inquiry.)

and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Suicide) Pistol shot in right ear
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) *Elijah J. Russell* M. D.
(Coroner.)
June 1, 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Oak Lawn*

DATE OF BURIAL, *June 3, 1915*

20-UNDERTAKER, *Philip Herwig*

ADDRESS *2016 Orleans St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85776

CERTIFICATE OF DEATH.

28

C85776

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 17 yrs., 10 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED, single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 3 - 1915

HARRY O. ANDREWS,

Filed

1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 10 1915, to June 1 1915,

that I saw him alive on May 31 1915,

and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lung
Duration 1 yrs. 10 mos. 21 ds.

CONTRIBUTORY (Secondary)

Lung
(Signed) Dr. G. L. Pennington, M. D.
June 1, 1915 (Address) 708 E. 100th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Int. Christ Cemetery

June 4, 1915

20-UNDERTAKER

ADDRESS

George Lehman & Bros

2101 Frederick Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85777

C85777

CERTIFICATE OF DEATH.

138

1-PLACE OF DEATH

CITY OF BALTIMORE, NO.

1273 Battery ave. 24

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Carrie Myrtle Cook

(Residence in Baltimore: No.

1273 Battery ave.

St.: Life Time Mos. da)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

June 28, 1892

7-AGE,

22 yrs. 11 mos. 6 da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Balto Md

PARENTS.

10-NAME OF FATHER,

John C Harwick

11-BIRTHPLACE OF FATHER (State or Country),

Penn.

12-MAIDEN NAME OF MOTHER

Sarah H. Hanna

13-BIRTHPLACE OF MOTHER (State or Country),

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John C Harwick

(Address) 1403 Williams St.

JUN 3 - 1915

HARRY O. ANDREWS

Filed 1915

Marial Permit 010

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

May 22 1915 to June 3 1915

that I saw her alive on June 3 1915

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

Child birth & dilatation

acute nephritis

(Duration) yrs. mos. da.

(Signed) Jas S. Sommers

June 30, 1915 (Address) 107 E. Mel St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

JUN 5 - 1915

ADDRESS

ARMSTRONG-DENNY CO.

715 Light

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85778

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 C85778
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *1* WARD)

FULL NAME

William Gillen
(Residence in Baltimore: No. *106 Robinson* St.: — yrs., — mos., — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11k.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)6-DATE OF BIRTH, *June*, *1873*
(Month) (Day) (Year)7-AGE, *42* yrs., — mos., — ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Son Worker*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *MD.*10-NAME OF FATHER, *James Gillen*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER *Mary O'Malley*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Gillen*(Address) *1384 110th St*15- *JUN 3 - 1915* HARRY O. ANDREWS,
Filed....., 191....., *Barial Permit* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 1*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 5* 1915, to *June 1* 1915that I saw him alive on *June 1* 1915and that death occurred, on the date stated above, at *10:35* a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy(Duration) *27* hrs., *1* mo., *1* ds.CONTRIBUTORY *General paresis* (Secondary) *Sclerosis*(Duration) *27* hrs., *1* mo., *1* ds.(Signed) *Edward J. Smith* M. D.*June 1*, 1915 (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs., — mos., — ds. In the *City* State..... yrs., — mos., — ds.Where was disease contracted, *106 Robinson St.*
if not at place of death?Former or usual residence *106 Robinson St.*19-PLACE OF BURIAL OR REMOVAL, *St Patrick* DATE OF BURIAL, *June 2, 1915*20-UNDERTAKER *John A. Moran* ADDRESS *Bank*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085779

HEALTH DEPARTMENT—CITY OF BALTIMORE

085779

CERTIFICATE OF DEATH

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *U. S. Marine Hospital* 12 WARD)

2-FULL NAME *Thomas Billings*

(Residence in Baltimore: No. *U. S. Marine Hospital* St.; yrs. mos. *10* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN aut No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *Colored* 5-SINGLE MARRIED *Single* WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH *8* *2* *1880*
(Month) (Day) (Year)

7-AGE *35* yrs. *2* mos. *2* ds. or min. If LESS than 1 day, — hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work *Seaman* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Md.*

PARENTS
10-NAME OF FATHER *unknown*
11-BIRTHPLACE OF FATHER (State or country) *unknown*
12-MAIDEN NAME OF MOTHER *unknown*
13-BIRTHPLACE OF MOTHER (State or country) *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE *From Hospital records.*
(Informant)

(Address)

JUN 3 - 1915

Filed

191

HARRY O. ANDREWS,

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *June 1* 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 21*, 1915, to, *June 1*, 1915, that I saw him alive on *May 31*, 1915, and that death occurred, on the date stated above, at *4 a. m.* The CAUSE OF DEATH* was as follows:

Tubercle of lung

(Duration) *Unknown*
Contributory (SECONDARY) *Tubercle of larynx*
(Duration) *Unknown*
(Signed) *McIntire* M. D.
June 2, 1915 [Address *U. S. Marine Hospital*]

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs. — mos. *10* ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death? *Unknown*

Former or usual residence *Unknown*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asbury Cemetery

June 3, 1915

20-UNDERTAKER

ADDRESS

H. E. Myers

17 S. Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85780

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85780

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

2-CITY OF BALTIMORE (No. *422 E. Biddle* ST. *10* WARD)

3-FULL NAME *George Herbert Rutter*

(Residence in Baltimore: No. *422 E. Biddle* St. *20* yrs. *0* mos. *0* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single* (Write the word)

6-DATE OF BIRTH *December 12, 1891* (Month) (Day) (Year)

7-AGE *23* yrs. *5* mos. *19* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *Lithographer at American Can Co.* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE *Southville, Balto. Co. Md.* (State or country)

PARENTS 10-NAME OF FATHER *Edward J. Rutter* 11-BIRTHPLACE OF FATHER *Balto. Md.* (State or country) 12-MAIDEN NAME OF MOTHER *Sophia Walker* 13-BIRTHPLACE OF MOTHER *Va.* (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Mrs. E. J. Rutter* (Address) *422 E. Biddle St.*

15-JUN 3 - 1915 *HARRY O. ANDREWS, Registrar*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 1st, 1915* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *April 22, 1915* to *May 31st, 1915*, that I saw him alive on *May 31st, 1915*, and that death occurred on the date stated above, at *9 P. m.* The CAUSE OF DEATH* was as follows:

Pericarditis

(Duration) *1* yrs. *9* mos. *9* ds. Contributory *Inflammatory Rheumatism* (SECONDARY) (Duration) *1* yrs. *1* mos. *9* ds. (Signed) *Wm. Conrad Bode* M. D. *June 2, 1915* (Address) *1900 Maryland Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death *0* yrs. *0* mos. *0* ds. In the State *0* yrs. *0* mos. *0* ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Gruid Ridge Cemetery* DATE OF BURIAL *June 4, 1915* ADDRESS *Henry W. Meier & Son, 10 S. N. Calvert St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85781

C85781

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1741 Ashland ave. ST. 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1741 Ashland ave. St.; 3 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE. <u>Colored</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <u>Single</u> (Write the word.)
6-DATE OF BIRTH. <u>May</u> , <u>1912</u> (Month) (Day) (Year)		
7-AGE. <u>3</u> yrs., <u></u> mos., <u></u> ds.		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		

9-BIRTHPLACE,
(State or Country),

PARENTS.	10-NAME OF FATHER. <u>John W Bailey</u>
	11-BIRTHPLACE OF FATHER (State or Country). <u>Maryland</u>
	12-MAIDEN NAME OF MOTHER <u>Mattie Deville</u>
	13-BIRTHPLACE OF MOTHER (State or Country). <u>Virginia</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Bailey(Address) 1741 Ashland Ave.

15- JUN 3 - 1915

HARRY O. ANDREWS,

Filed....., 191.....

Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June, 1, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 31 1915, to June 1 1915, that I saw her alive on May 31 1915, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)(Duration)..... yrs..... mos..... ds.
(Signed) Walter W. White M. D.
June 1, 1915. (Address) 1161 Bivona

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel Cemetery June 3, 1915
20-UNDERTAKER Chas H Bailey

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85782

C85782

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *2421 Fair Ave* ST. *1* WARD)

2-FULL NAME

Anna Kowaleski

(Residence in Baltimore: No.

2421 Fair Ave

St. *1* yrs. *1* mos. *1* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and HC out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-STATUS *Married*
(Write the word)

6-DATE OF BIRTH *June 24, 1892*
(Month) (Day) (Year)

7-AGE *22* yrs. *11* mos. *6* ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work *House-work*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore*

PARENTS
10-NAME OF FATHER *Martin Kaczarowski*
11-BIRTHPLACE OF FATHER (State or country) *Germany*
12-MAIDEN NAME OF MOTHER *Hanislawa Spirska*
13-BIRTHPLACE OF MOTHER (State or country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Hanislawa Kaczarowska*
(Address) *2421 Fair Ave.*

15-JUNE 5 - 1915
FED. REG. 191
HARRY O. ANDREWS,
Marial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 2, 1915*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *June 1, 1915*, to *June 2, 1915*,
that I saw her alive on *June 1, 1915*,
and that death occurred, on the date stated above, at *29* m.
The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

Contributory (SECONDARY) *Exhaustion*
(Duration) yrs. *5* mos. *1* ds.

(Signed) *Chas. Neely* M. D.
6/2/15 191 [Address] *405 S. Ann St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *St. Stanislaus* DATE OF BURIAL *June 4, 1915*

20-UNDERTAKER *M. F. Sadowski* ADDRESS *705 S. Ann St.*

C85783

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85783

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hoap for Women of Md* REGISTERED NO. C
 CITY OF BALTIMORE: (No. *13* ST. *13* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18a)
 2-FULL NAME *Mrs Clara Simon*
 (Residence in Baltimore: No. *2020 Linden Ave* St.: *64* yrs., *9* mos., *11* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *Widow*
 (Write the word.)

6-DATE OF BIRTH, *Sept 22*, 1850
 (Month) (Day) (Year)

7-AGE, *64* yrs., *9* mos., *11* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *none*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *Heinsfelder*
 11-BIRTHPLACE OF FATHER (State or Country), *Germany*
 12-MAIDEN NAME OF MOTHER, *not known*
 13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. P. Hantz*

(Address) *Hoap for Women of Md*

15- JUN 3 - 1915 HARRY O. ANDREWS,

Filed..... 191... Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 1*, 1915.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr 15* 1915, to *June 1* 1915, that I saw her alive on *June 1* 1915, and that death occurred, on the date stated above, at 9:50 p.m. The CAUSE OF DEATH* was as follows:

Myocardial Inter. Hypertrophy

(Duration) *2* yrs., *1* mos., *25* ds.
 CONTRIBUTORY *Intestinal-Vaginal Fistula*
 (Secondary)

(Signed) *A. P. Hantz* M. D.
June 1 1915. (Address) *W. Wilson's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *3* mos. *3* ds. In the State *50* yrs. *2* mos. *2* ds.

Where was disease contracted, if not at place of death? *2020 Linden Ave*

Former or usual residence: *2020 Linden Ave*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *June 4*, 1915.

Heaven Burial Ship

20-UNDERTAKER, ADDRESS *Heaven Burial Ship*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40
REGISTERED NO. C

C85784

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1303 Homewood ave St. 9

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Augustus Pugsley

(Residence in Baltimore: No.

1303 Homewood ave

St.; 67 yrs., 6 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *buried*
(Write the word.)

6-DATE OF BIRTH

November 12th, 1847
(Month) (Day) (Year)

7-AGE

67 yrs., 6 mos., 20 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Teamster

9-BIRTHPLACE,
(State or Country),

Baltimore Md

PARENTS.

10-NAME OF FATHER,

John H Pugsley

11-BIRTHPLACE OF FATHER
(State or Country),

New York

12-MAIDEN NAME OF MOTHER

Margaret Conway

13-BIRTHPLACE OF MOTHER
(State or Country),

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

John W. Pugsley

(Address).....

814 W. Franklin st.

JUN 3 - 1915

HARRY O. ANDREWS,

Filed..... 191. Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 12th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 6 1915, to June 12th 1915,

that I saw him alive on May 31 1915,

and that death occurred, on the date stated above, at 1030 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Pharynx
(Clinical Diagnosis)
(Duration)..... yrs. 3 mos. ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... W. M. P. M. D.

June 2, 1915. (Address)..... S. E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL

June 4th, 1915.

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E Monument st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85785

C85785

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

810 E Preston

ST.;

9

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Agnes M. Sheares

(Residence in Baltimore: No.

810 E Preston

St.;

Life

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED, Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

February 25, 1883

(Month)

(Day)

(Year)

7-AGE

72 yrs. 8 mos. 8 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),

Baltimore Md

10-NAME OF FATHER

Alexander Carr

11-BIRTHPLACE OF FATHER
(State or Country),

Scotland

12-MAIDEN NAME OF MOTHER

Ann Melroy

13-BIRTHPLACE OF MOTHER
(State or Country),

Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William Sheares

(Address)

810 E Preston St

JUN 3 - 1915

HARRY O. ANDREWS,

191. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 2nd, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1st 1915, to June 2nd 1915,that I saw h^e alive on June 1st 1915,

and that death occurred, on the date stated above, at 2:00 a.m.

The CAUSE OF DEATH* was as follows:

Ch. pulm. embolism

Ch. nephritis (acute)

(Duration) 5 yrs. 3 mos. 8 ds.

CONTRIBUTORY (Secondary)

Oldema. t. Arteriosclerosis

(Duration) 3 yrs. 3 mos. 8 ds.

(Signed) J. H. Andrews, M.D.

June 2nd, 1915. (Address) 2844 St. Anne St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Cemetery

DATE OF BURIAL

June 4th, 1915

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Monument St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85786

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85786

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *St. Joseph's Hospital*)
2-FULL NAME *Margaret Schuman*
(Residence in Baltimore: No. *1709 N. Castle*)

8
WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, <i>Female</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>Married</i> (Write the word.)
6-DATE OF BIRTH, <i>June 1</i> (Month) (Day) (Year)		
7-AGE, <i>43</i> yrs. mos. da.		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work... (b) General nature of industry, business, or establishment in which employed (or employer)...		
9-BIRTHPLACE, (State or Country), <i>md</i>		
10-NAME OF FATHER, <i>John Hensel</i>		
11-BIRTHPLACE OF FATHER, (State or Country), <i>md</i>		
12-MAIDEN NAME OF MOTHER, <i>Paulina Brown</i>		
13-BIRTHPLACE OF MOTHER, (State or Country), <i>md</i>		

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George F. Ruth*

(Address) *1735 N. Harford*

15-JUN 3 - 1915

HARRY O. ANDREWS,

Filed... 191...
Registral Permit...
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,
June 1, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...
(Inquest, autopsy or inquiry.)

thereof and from the evidence obtained by said...
(Inquest, au-

Inquiry... and that said deceased came to death...
(topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

(Suicide) Rickards J. Mercury Poisoning

(Duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) *Oliver J. Russell* M. D.

(Coroner.)

June 1, 1915. (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. da. In the *43* yrs. mos. da.

Where was disease contracted if not at place of death?

1709 N. Castle St

Former or usual residence *1709 N. Castle St*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oak Lawn Cemetery

June 3, 1915

20-UNDERTAKER

ADDRESS

George F. Ruth

1735 N. Harford

C85787

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85787

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Franklin St. 6

WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Matilda Lovett

(Residence in Baltimore: No.

23 N. Wolfe St.

St. 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH.

Unknown, 1
(Month) (Day) (Year)

7-AGE,

52 yrs., mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
Wife

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Schultz

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice Hammerschmitt

(Address) 23 N. Wolfe St.

15-

JUN 3 - 1915

Filed 1915

Baltimore City Health Department Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 17, 1915, to June 3, 1915, that I saw her alive on June 3, 1915, and that death occurred, on the date stated above, at 12 a. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver
(Duration) 1 yrs., mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Geo. A. Smarr M. D.
6/3/15, 1915 (Address) Franklin St. 6

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 23 N. Wolfe St.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Holy Redeemer Church, June 7, 1915

20-UNDERTAKER ADDRESS

W. J. Turner 14424 Bldg

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85788

C85788

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1332 Webster* ST.; *24* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Marvin J. Clark*(Residence in Baltimore: No. *1332 Webster* St.; *7* yrs., *10* mos. *26* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *July 7, 1907*

(Month)

(Day)

(Year)

7-AGE, *7* yrs., *10* mos., *26* da.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *Luke W. Clark*11-BIRTHPLACE OF FATHER, (State or Country), *Md.*12-MAIDEN NAME OF MOTHER, *Elizabeth Hanger*13-BIRTHPLACE OF MOTHER, (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Clark*(Address) *1332 Webster*

15-

JUN 3 - 1915.

REGISTRAR. *Q. A. M.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 3, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 31, 1915*, to *June 3, 1915*,that I saw him alive on *June 3, 1915*,and that death occurred, on the date stated above, at *9 A* m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever(Duration).....yrs.....mos.....da. *4*CONTRIBUTORY *acute Lobar pneumonia*

(Secondary)

(Duration).....yrs.....mos.....da. *3*(Signed) *R. R. Campbell* M. D.*June 3, 1915* (Address) *1644 E. Howard St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cathedral Cemetery*DATE OF BURIAL, *June 4, 1915*20-UNDERTAKER *H. G. M. Flynn*ADDRESS *1422 Light St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85789

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85789

CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1905 Penrose Ave ST. 20 WARD)
2-FULL NAME Herman Leppe (Leppe)
(Residence in Baltimore: No. 1905 Penrose Ave Str. yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)
6-DATE OF BIRTH Dec 19th, 1955 (Month) (Day) (Year)
7-AGE 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION (a) Trade, profession, or particular kind of work Sheet iron worker (b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE (State or country) Baltimore Md
10-NAME OF FATHER Henry W. Leppe
11-BIRTHPLACE OF FATHER (State or country) Germany
12-MAIDEN NAME OF MOTHER Hannah ?
13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

JUN 3 - 1915

ROBERT KRAUTER

Morial Death Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 1, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 14, 1915 to June 1, 1915. that I saw him alive on May 30th, 1915 and that death occurred, on the date stated above, at 7-30 A m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.
Contributory (SECONDARY) Hampton

(Signed) Raymond Nelson M. D.
June 3, 1915 (Address) 404 N Payson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Cemetery

June 4, 1915

20-UNDERTAKER

ADDRESS

F. A. Krause

703 Hamover

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85790

CERTIFICATE OF DEATH.

104 C85790
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1360 Carroll St.; 21 WARD)

2-FULL NAME

Evelyn Mary Buckler

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 19.)

(Residence in Baltimore: No. 1360 Carroll St. yrs. 6 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Nov 18

(Month)

(Day)

1914 (Year)

7-AGE,

yrs. 6 mos. 15 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

John F. Buckler

11-BIRTHPLACE OF FATHER (State or Country),

Carroll Co. Md.

12-MAIDEN NAME OF MOTHER

Elizabeth Walter

13-BIRTHPLACE OF MOTHER (State or Country),

Delaware Co. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Buckler

(Address) 1360 Carroll St.

15- JUN 3 - 1915.

ROBERT KRAUTER

Filed 1915

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

6 / 2 / 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

6 / 2 / 1915, to 6 / 3 / 1915,

that I saw him alive on 6 / 3 / 1915,

and that death occurred, on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Esher's Endocarditis

(Duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Auto Intoxication

(Duration) yrs. 3 mos. 3 ds.

(Signed) J. H. Smith M. D.

June 3, 1915 (Address) 1527 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL,

June 4, 1915

20-UNDERTAKER

Mrs. J. E. Evans & Sons 142 E. Charles St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85791

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mon. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Black

5-SINGLE,
MARRIED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH.

May 17, 1915

7-AGE.

4 yrs. 4 mos. 4 ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF FATHER,

Harry A. Cooper

11-BIRTHPLACE OF FATHER
(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Westlin Cooper

13-BIRTHPLACE OF MOTHER
(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 3 - 1915

ROBERT

JONES

FRI

191

JUN 12

JUN 12

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 31, 1915

17- I HEREBY CERTIFY, That I attended deceased from

May 17, 1915, to May 31, 1915,

that I saw him alive on May 27, 1915,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from umbilical
cord stumpCONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Edward Smith M. D.

6-1, 1915. (Address) Mersey Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? 914 Peach Alley

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

MCKINNS HOSPITAL

JUN 3 - 1915

20-UNDERTAKER

ADDRESS

Commissioner Health

Per. Wm. E. WOODALL.

FOR ANATOMICAL PURPOSES.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE CLEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

C85792

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85792

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *3165 Leeds*)

2-FULL NAME *George D. Piquett*

(Residence in Baltimore: No. *3165 Leeds*)

REGISTERED No. C

ST. *20* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-STATUS

Widowed

Widowed

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

Feb 15, 1854
(Month) (Day) (Year)

7-AGE

61 yrs. 3 mos. 16 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

General Laborer

9-BIRTHPLACE

(State or country)

Baets Md

10-NAME OF FATHER

John Piquett

11-BIRTHPLACE OF FATHER

(State or country)

Md

12-MAIDEN NAME OF MOTHER

Catherine Hooe

13-BIRTHPLACE OF MOTHER

(State or country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo L Piquett

(Address)

2124 N. Harwood

15.

JUN 3 - 1915

ROBERT J. KRAUTER,

Filed

191

Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 1, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from

Oct 20, 1914 to *June 1, 1915*

that I saw him alive on *June 1, 1915*

and that death occurred, on the date stated above, at *5:30 p. m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(Duration) yrs. mos. ds

Contributory

(SECONDARY)

General Extension

(Duration) yrs. mos. ds

(Signed) *W. A. Sweet* M. D.

June 2, 1915 (Address) *Irvington*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cathedral Cemetery

DATE OF BURIAL

JUN 4 - 1915

20-UNDERTAKER

Geo A Gerbig

ADDRESS

Baets & Payne

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Chur de Home & Infirmary*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *629 N. Schroeder St*)St.; *53* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*white*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

April *18* *1862*
(Month) (Day) (Year)

7-AGE.

53 yrs. mos. ds. hrs. or min.?
If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Dressmaker*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),*Balto Md*

10-NAME OF FATHER,

Jeremiah Scully

11-BIRTHPLACE OF FATHER

(State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER

Annie

13-BIRTHPLACE OF MOTHER

(State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Rose Scully*(Address) *629 N. Schroeder St*

15-

JUN 3 - 1915 *ROBERT M. KRAUTH*
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May *31* *1915*
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *May 29* 1915, to *May 31* 1915, that I saw her alive on *May 31* 1915, and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)(Signed) *James Reichard* M. D.
May 31 1915 (Address) *Chur de Home & Inf*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the *53* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Baltimore Md.*

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cemetery

DATE OF BURIAL,

6 - 4 - 1915

20-UNDERTAKER

W B Ranning

ADDRESS

517 N. Schroeder

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85791

CERTIFICATE OF DEATH.

150 C85791
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *22* ST.; *22* WARD)

2-FULL NAME

(Residence in Baltimore: No. *672 S. Calver St.* St.; yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Black

5-SINGLE,

*Married**Widowed**or Divorced*

(Write the word.)

6-DATE OF BIRTH.

May 24, 1915
(Month) (Day) (Year)

7-AGE.

yrs. mos. *9* da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), *Balt. Md.*

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER

(State or Country), *Md.*

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert Mercy Hosp.*(Address) *Calvert St.*

15-

JUN 3 - 1915

ROBERT

KRAUTER,

Serial *100015* Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 24, 1915, to June 2, 1915*that I saw him alive on *June 2, 1915*and that death occurred, on the date stated above, at *5259* St.

The CAUSE OF DEATH* was as follows:

Patent Protrusion of the

(Duration).....yrs.....mos.....da.

CONTRIBUTORY

(Secondary)

(Duration).....yrs.....mos.....da.

(Signed) *Edward H. Smith* M. D.*June 3, 1915* (Address) *Mary Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State *La.* yrs. mos. da.Where was disease contracted, if not at place of death? *Mary Hosp.*Former or usual residence *Mary Hosp.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Auburn *June 4, 1915*

20-UNDERTAKER

ADDRESS

L. Brown & Son *108 N. Maryland*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 W Cross)ST.: 21 WARD

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Francis M. Ahern(Residence in Baltimore: No. 1010 W Cross)St.: 29 yrs., 5 mon., 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Oct 25, 1885
(Month) (Day) (Year)

7-AGE,

29 yrs., 5 mos., 16 ds.

IF LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country), Baltimore

10-NAME OF FATHER,

John P. Ahern

11-BIRTHPLACE OF FATHER,

(State or Country), Baltimore

12-MAIDEN NAME OF MOTHER

Rosa Lang

13-BIRTHPLACE OF MOTHER

(State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Ahern(Address) 1010 W Cross

JUN 3 - 1915

ROBERT J. KRAUTER

Serial Permit to Burial

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 2 1915, to Jan 15 1915,
that I saw her alive on May 31 1915,and that death occurred, on the date stated above, at 230 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 5 yrs., 5 mos., 5 ds.CONTRIBUTORY
(Secondary)(Duration) 1 yrs., 1 mos., 1 ds.(Signed) S. J. Ahern M. D.June 15, 1915. (Address) 517 W Cross

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 29 yrs., 5 mos., 16 ds. In the State 29 yrs., 5 mos., 16 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cemetery

DATE OF BURIAL,

June 4, 1915

20-UNDERTAKER

James Dignan & Son

ADDRESS

1011 S. Paca St.

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85796

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85796

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *937 Somerset*)ST.: *10*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Appollonia Huelserman(Residence in Baltimore: No. *937 Somerset*)St.; *84* yrs... *9* mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH.

Aug 26, 19*10*
(Month) (Day) (Year)

7-AGE.

54 yrs... *9* mos. *6* ds.

IF LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE.

(State or Country).

Balt Md.

10-NAME OF FATHER.

Martin Sahlender

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER.

Margaret Schuck

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Geo. Rappelt

(Address)

937 Somerset St.

15-

FILED

JUN 3 - 1915

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 2, 191*5*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Feb 15, 191*5*, to *June 2*, 191*5*.that I saw him alive on *June 1*, 191*5*.and that death occurred, on the date stated above, at *1:40* p.m.

The CAUSE OF DEATH* was as follows:

Asthma
(Duration) ... yrs. ... mos. *15* Mo.

CONTRIBUTORY

(Secondary)

Emphysema
(Duration) ... yrs. *3* mos. ... ds.(Signed) *F. M. Rappelt* M. D.*June 2*, 191*5* (Address) *77 Calver*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Redemer Cemetery *June 4*, 191*5*

20-UNDERTAKER

Henry Beck

ADDRESS

130 E. Regent St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168 085797

PLACE OF DEATH

CITY OF BALTIMORE (No. *1800 E Biddle*)

ST. *8*

WARD)

FULL NAME

Albert Schissler

(Residence in Baltimore: No. *1800 E Biddle*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *30* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Nov 3rd 1869
(Month) (Day) (Year)

7-AGE,

45 yrs. *6* mos. *29* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Cabinet Maker

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER, (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER, (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs Anna Schissler

1800 E Biddle St

15-

FBI

JUN 3 - 1915

ROBERT KRAETZ

Surgeon General

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 2nd 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*
(Inquest, au-

topsy or inquiry.) and that said deceased came to *his* death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation Illuminating Gas (Accidental)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Elijah J. Russell* M. D.

(Coroner.)

June 5, 1915 (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery

June 5, 1915

20-UNDERTAKER

ADDRESS

Henry Horst Sen

1801 E Biddle St

THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10

C85798

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 218 No. Mountford Ave

2 FULL NAME

William J. Goss

(Residence in Baltimore: No. 218 No. Mountford Ave

ST. 6

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

December 1st, 1872 (Month) (Day) (Year)

7 AGE

44 yrs. 6 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Labourer

9 BIRTHPLACE

(State or country)

Baltimore Co Md

10 NAME OF FATHER

William J. Goss

11 BIRTHPLACE OF FATHER (State or country)

Danvers Co

12 MAIDEN NAME OF MOTHER

Katharina J. Howard

13 BIRTHPLACE OF MOTHER (State or country)

Tackett Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William J. Goss

(Address)

218 Bradford St.

JUN 3 - 1915

Filed

191

RUBEN . KRATIER, Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 3rd, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 21, 1915, to June 3, 1915.

that I saw him alive on June 1, 1915.

and that death occurred, on the date stated above, at 3:50 a.m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. 9 ds.

Contributory (SECONDARY)

Spiceough

(Duration) yrs. mos. 3 ds.

(Signed)

Dr. Spencer (Address) 330 7th St. N.W.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Ashbury Cemetery

DATE OF BURIAL

June 5, 1915

20 UNDERTAKER

ADDRESS

Milton Davis - 1608 McElderry St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085799 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2660 W. North Ave. 15

ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert J. Morris

(Residence in Baltimore: No. 2660 W. North Ave.

Sr. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED (If married, give word) Widowed

6-DATE OF BIRTH Unknown, 1857 (Month) (Day) (Year)

7-AGE 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Builder

9-BIRTHPLACE (State or country) Va.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Va.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Morris (Address) 2660 W. North Ave.

15-JUN 3 - 1915, ROBERT J. KRAUTER, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 2, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 24, 1915, to June 2, 1915, that I saw him alive on " 2, 1915, and that death occurred, on the date stated above, at 11:55 P.M. The CAUSE OF DEATH* was as follows:

Myocarditis & Anemia

Contributory (SECONDARY) Probable Myocarditis (Duration) 1 yrs. mos. ds. (Signed) J. J. McLean M. D. June 3, 1915 (Address) 1303 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

20-UNDERTAKER

DATE OF BURIAL

June 6, 1915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *600 N. Decker Ave* ST. *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *600 N. Decker Ave* St. *7* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*6-DATE OF BIRTH, *November 28, 1844*
(Month) (Day) (Year)7-AGE, *70* yrs. *6* mos. *5* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *House work*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Germany*

PARENTS.	10-NAME OF FATHER,	<i>Unknown</i>
	11-BIRTHPLACE OF FATHER (State or Country),	<i>Unknown</i>
	12-MAIDEN NAME OF MOTHER	<i>Unknown</i>
	13-BIRTHPLACE OF MOTHER (State or Country),	<i>Unknown</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Gotthart Meinel*(Address) *600 N. Decker Ave*15-*JUN 4, 1915* HARRY O. ARKINS, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 2, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 1st* 1912, to *June 2nd* 1915, that I saw her alive on *June 2nd* 1915, and that death occurred, on the date stated above, at *10 P. M.* The CAUSE OF DEATH was as follows:*Lobar Pneumonia*
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Signed) *C. N. B. B. B.* M. D.
June 3rd, 1915. (Address) *100 S. O. B. B. B.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Bernard Cemetery* DATE OF BURIAL, *June 4th, 1915*20-UNDERTAKER, *Christian Muller* ADDRESS *2334 Jefferson St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

145
C85801
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 Biddle ST., 17 WARD)

2-FULL NAME

Mary E. Cook
(Residence in Baltimore: No. 526 W. Biddle St.; 70 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE,

Married
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 1845
(Month) (Day) (Year)

7-AGE

70

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Domestic9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

Henry Brown

11-BIRTHPLACE OF FATHER

(State or Country),

Mo.

12-MAIDEN NAME OF MOTHER

Mary A. Felton

13-BIRTHPLACE OF MOTHER

(State or Country),

Mo.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet A. Smith(Address) 526 W. Biddle St.

15-

HARRY O. ANDREWS

Filed JUN. 4. 1915

Burial Permit 0107

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

6/1, 1915.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

526 1915, to 6/1 1915,that I saw him alive on 6/1 1915,and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)Supp. by ul-(Signed) A. L. E. E. E. M. D.6/2, 1915 (Address) 724 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

St. Paul June 3, 1915

20-UNDERTAKER

ADDRESS

Sam H. Chase 1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85802

CERTIFICATE OF DEATH

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *WARD*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME

Niccolata Maranto Duffalo(Residence in Baltimore: No. *502 N Calvert St* St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Unknown, 1849
(Month) (Day) (Year)

7-AGE,

66 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *House wife*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Italy

10-NAME OF FATHER,

A. Maranto

11-BIRTHPLACE OF FATHER (State or Country),

Italy

12-MAIDEN NAME OF MOTHER

A. Braccio

13-BIRTHPLACE OF MOTHER (State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Samuel Citron*(Address) *2826 E. Lexington St.*

15-

JUN 4 - 1915

HARRY O. ANDREWS,

Filed

191

Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 27, 1915*, to *June 3, 1915*, that I saw her alive on *June 3, 1915*, and that death occurred, on the date stated above, at *11:40 a.m.*

The CAUSE OF DEATH* was as follows:

Acute dilation of heart following forebrain from intestinal obstruction of Peritonitis (Duration) ... yrs. ... mos. *7.2* ds.

CONTRIBUTORY (Secondary)

Acute Ruptures Appendix (Duration) ... yrs. ... mos. *4* ds.(Signed) *R. L. Johnson* M. D.*June 3, 1915* (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. *7* ds. *10* yrs. ... mos. ... ds.Where was disease contracted, if not at place of death? *501 N Calvert St*Former or usual residence *502 N Calvert St*

19-PLACE OF BURIAL OR REMOVAL,

St Vincent Cem

DATE OF BURIAL,

... 191...

20-UNDERTAKER

William Cook

ADDRESS

502 E North St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28
REGISTERED NO. C

C85803

PLACE OF DEATH

CITY OF BALTIMORE (No. 1411 Hanover

ST.: 23

WARD)

2-FULL NAME Katherine Kordula

(Residence in Baltimore: No. 1411 Hanover

St.: yrs., 2 mos. 6 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

March

28

1893

(Month)

(Day)

(Year)

7-AGE,

42

Yrs.

2

mos.

6

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Henry Weller

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Elisea Waldschmidt

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Gaston J. Kordula

(Address)

1411 Hanover St.

15-

JUN 4 - 1915

HARRY O. ANDREWS,

Filed

191

Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan

3

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Phthisis

Tuberculosis

(Duration)

3

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(Duration)

3

yrs.

mos.

ds.

(Signed)

John J. ...

(Coroner)

Jan 3, 1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Linden Park

DATE OF BURIAL,

June 5, 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E. North St.

C85804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Mercy Hospital* ST. *2* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *125 S. Chapel St.* St.; *—* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH,

Oct. 5, 1909
(Month) (Day) (Year)

7-AGE,

5 yrs. 8 mos. — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Md.*

10-NAME OF FATHER,

Paul Annmiller

11-BIRTHPLACE OF FATHER

(State or Country), *Md.*

12-MAIDEN NAME OF MOTHER

Dora Link

13-BIRTHPLACE OF MOTHER

(State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Dora Annmiller*(Address) *125 S. Chapel St.*

15-

Filed

JUN 4 - 1915

191

HARRY O. ANDREWS,
Serial *Permit* *Ala*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 18, 1914*, to *June 3, 1915*, that I saw her alive on *June 3, 1915*, and that death occurred, on the date stated above, at *7:30 P.M.*

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis
following Diphtheria
about
(Duration) *10* yrs. *10* mos. *—* ds.CONTRIBUTORY
(Secondary)(Signed) *Edward P. Smith* M. D.
June 3, 1915 (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *9* yrs. *10* mos. *10* ds. In the *State* *La.* *—* ds.Where was disease contracted, if not at place of death? *125 S. Chapel St.*Former or usual residence *125 S. Chapel St.*

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

June 3, 1915

20-UNDERTAKER,

Jos. J. Kerr 1914 *E. Fayette*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85805

CERTIFICATE OF DEATH.

170 C85805
REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 Emory ST.; 22 WARD)

2-FULL NAME

(Residence in Baltimore: No. 310 Emory St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and apt. No. 18.)

St.; Lifton mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

January 17, 1874
(Month) (Day) (Year)

7-AGE,

41 yrs. 4 mos. 15 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Structural Iron worker(b) General nature of industry, business, or establishment in which employed (or employer) Rivets9-BIRTHPLACE,
(State or Country),Baltimore, Md

10-NAME OF FATHER,

Emory Eslinger11-BIRTHPLACE OF FATHER
(State or Country),Balt Md

12-MAIDEN NAME OF MOTHER

Rose Pfeiffer13-BIRTHPLACE OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emory Eslinger(Address) Pennington St

15-

Filed

JUN 4 1915

HARRY O. ANGLER,

Bureau of Health, City of Baltimore.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 12 1915, to June 1, 1915,that I saw him alive on June 1, 1915,and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis,Acute Cardiac Dilatation.
(Duration) 8 yrs. 8 mos. 15 ds.CONTRIBUTORY
(Secondary)Acute Cardiac Dilatation.
(Duration) 2 yrs. 2 mos. 15 ds.(Signed) J. M. DeLorette M. D.June 1, 1915 (Address) 621 Columbia Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Burial

DATE OF BURIAL,

June 4, 1915

20-UNDERTAKER

Geo Leinback

ADDRESS

347 M St

C. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S MORTUARY STATEMENT OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85806

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3034 Dillon* ST.: *1* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *3034 Dillon* St.: *50* yrs. mos. da)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Female</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>Married</i> (Write the word.)
6-DATE OF BIRTH, <i>July 10, 1844</i> (Month) (Day) (Year)		
7-AGE, <i>70 yrs. 10 mos. 23 da.</i> If LESS than 1 day, ... hrs. or ... min.		

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *at home*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Griffith W. Thomas*(Address), *3034 Dillon St.*

15-

JUN 4 - 1915

HARRY O. ANDREWS,

Filed..... 1915.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 2, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 17, 1915*, to *June 2, 1915*, that I saw her alive on *June 1, 1915*, and that death occurred, on the date stated above, at *3 40 A.M.*
The CAUSE OF DEATH* was as follows:*La Grippe*
(Duration)..... yrs. mos. *7* da.CONTRIBUTORY
(Secondary)(Signed)..... *D.W. Jones* M. D.
June 2, 1915 (Address)..... *316 Oronell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oaklawn

DATE OF BURIAL,

May 3, 1915

20-UNDERTAKER

Frank J. Jickler

ADDRESS

1739 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85807

CERTIFICATE OF DEATH.

147 C85807
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 Robinson St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred V. Zitzer (Zitzer)

(Residence in Baltimore: No. 312 Robinson St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single6-DATE OF BIRTH, Dec 25, 1908
(Month) (Day) (Year)7-AGE, 6 yrs. 5 mos. 8 ds.
If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. — None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Albert Zitzer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Grace Cox

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Albert Zitzer

(Address)..... 312 Robinson St.

15- JUNE 4 - 1915 BABBY O. ANDREWS,

Funeral Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 26 1915, to June 2 1915,

that I saw her alive on June 1 1915,

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Arteriosclerosis X
Infection from enlarged tonsils
(Duration)..... yrs. 0 mos. 10 ds.CONTRIBUTORY.....
(Secondary)(Signed)..... J. E. Harrison, M. D.
June 3, 1915 (Address)..... 3600 Hampden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, June 3 1915

20-UNDERTAKER, Philip Herwig Orleans

ADDRESS 2816

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

C85803

PLACE OF DEATH

CITY OF BALTIMORE (No. *921 S Fremont Ave* ST. *22* WARD)

FULL NAME

Mamie Mc Luigg

Residence in Baltimore: No.

921 S Fremont Ave

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St *22* yrs. *2* mos. *15* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

May 19, 1878
(Month) (Day) (Year)

7-AGE,

35 yrs. *2* mos. *15* da.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country).

Balt Md

10-NAME OF FATHER,

Henry J Carter

11-BIRTHPLACE OF FATHER (State or Country).

Md

12-MAIDEN NAME OF MOTHER

Mary Wiffen

13-BIRTHPLACE OF MOTHER (State or Country).

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Walter Mc Luigg*

(Address) *921 S Fremont Ave*

15-

Filed *JUN 4 - 1915* *HARRY O. ANDREWS,*
Bureau Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart failure

Chorea

(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... da.

(Signed) *E. B. Harle* M. D.

(Coroner.)

June 3, 1915 (Address) *17 S. 17 St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill

DATE OF BURIAL,

June 4, 1915

20-UNDERTAKER

E. B. Harle

ADDRESS

115 E. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85800

C85800

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 4 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

JUN 4, 1915

HARRY O. ANDREWS,

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

(Month) (Day) (Year)

17-I HEREBY CERTIFY That I attended deceased from

April 1915, to June 28, 1915,

that I saw her alive on June 1st, 1915,

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 6 yrs. 6 mos. 6 ds.

CONTRIBUTORY
(Secondary)

(Duration) 1 yr. 11 mos. 11 ds.

(Signed) A. L. Ellis M. D.

1915 (Address) 727 N. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yr. 11 mos. 11 ds. In the State 1 yr. 11 mos. 11 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mt. Auburn Cem.

June 4, 1915.

20-UNDERTAKER

Edw. W. Pye

ADDRESS

61 Winters ave
Catonsville, Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85811

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85811

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 363 Fort Hill Ave ST. 70 WARD)
2-FULL NAME William J M'Vey
(Residence in Baltimore: No. 363 Fort Hill Ave St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS
3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) widower
6-DATE OF BIRTH Unknown, 1836 (Month) (Day) (Year)
7-AGE (69) 69 yrs. mos. ds. or min.?
8-OCCUPATION (a) Trade, profession, or particular kind of work carpenter. (b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE (State or country) Port Deposit Md
10-NAME OF FATHER Levi M'Vey
11-BIRTHPLACE OF FATHER (State or country) Md
12-MAIDEN NAME OF MOTHER Mary Jenkins
13-BIRTHPLACE OF MOTHER (State or country) Ark. Mo.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs B M'Vey
(Address) 363 Fort Hill Ave

15. JUN 4 - 1915 HARRY O. ANDREWS, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH
16-DATE OF DEATH June 3rd, 1915 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 3rd, 1915, to June 3rd, 1915, that I saw him alive on June 2, 1915, and that death occurred, on the date stated above, at 11 a. m. The CAUSE OF DEATH* was as follows:
Chronic Tuberculosis
Nephritis
(Duration) 1 yrs. mos. ds.
Contributory (SECONDARY) Chronic Cough (Duration) yrs. mos. 3 ds.
(Signed) J. A. Hill M. D. June 3, 1915 (Address) Springton
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence
19-PLACE OF BURIAL OR REMOVAL Off Street Cem. DATE OF BURIAL June 4th, 1915
20-UNDERTAKER Charles H. Hill. ADDRESS 3109 E. 4th Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85812

CERTIFICATE OF DEATH.

71
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 7078 Bond ST. V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

FULL NAME Rozimir G. Lewinsky

Residence in Baltimore: No. 7078 Bond St.

St.: yrs. 5 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOW, OR DIVORCED.

Single (Write the word.)

6-DATE OF BIRTH.

Dec. 29, 1914

(Month)

(Day)

(Year)

7-AGE.

5

mos.

7

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

Infant

9-BIRTHPLACE, (State or Country).

Baltimore -

10-NAME OF FATHER.

Jan Lewinsky

11-BIRTHPLACE OF FATHER (State or Country).

Rusni Poland

12-MAIDEN NAME OF MOTHER.

Johanna Zion

13-BIRTHPLACE OF MOTHER (State or Country).

Galicia Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Jan Lewinsky

(Address).

7078 Bond St.

15-

JUN 4 - 1915

DEPT. OF HEALTH

Filed.

101.

Burial Permit No.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 24, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

June 3, 1915, to June 4, 1915,

that I saw him alive on June 4, 1915,

and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. J. Brown D.

June 4, 1915 (Address) 2005 E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds. State ...

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Rosary

DATE OF BURIAL.

June 5, 1915

20-UNDERTAKER

William Gialkowski

ADDRESS

1618 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85913

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85913

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.;

yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

16-DATE OF DEATH,

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

FILE

JUN 4 - 1915

HARRY O. ANDREWS,

21-121 PERMIT 018

Registrar.

MEDICAL CERTIFICATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

that I saw h—alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85914

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *932 N. Stricker* ST.; *16* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Kathryn R. Starkey*(Residence in Baltimore: No. *932 N. Stricker* St. St.: - yrs. - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

July 25, 1895
(Month) (Day) (Year)

7-AGE,

17 yrs. 10 mos. 10 da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country).

Ind. -

10-NAME OF FATHER,

Isaac R. Starkey

11-BIRTHPLACE OF FATHER

(State or Country),

Ind

12-MAIDEN NAME OF MOTHER

Rottie M. Rolph

13-BIRTHPLACE OF MOTHER

(State or Country),

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Rottie M. Starkey*(Address) *932 N. Stricker St*15- *JUN 4 - 1915*

Filed..... 191.....

HARRY O. ANDREWS

Marial For...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 2 1915, to June 3 1915,*that I saw her alive on *June 3 1915,*and that death occurred, on the date stated above, at *5 P. m.*

The CAUSE OF DEATH* was as follows:

chronic valvular Heart Disease(Duration) *4* yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *A. M. Harrison* M. D.*June 4, 1915* (Address) *1022 West Lafayette Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Dundeeville Ind. June 5, 1915

20-UNDERTAKER

ADDRESS

Chas. Mitchell 1602 N. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85815

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 C85815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

505 Apple Court 7

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Lillie May Trusty

(Residence in Baltimore: No.

505 Apple Court

St.; — yrs., 8 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

Sept

5

1914

(Month)

(Day)

(Year)

7-AGE,

8

29

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

City

10-NAME OF FATHER,

Eugene Trusty

11-BIRTHPLACE OF FATHER,

(State or Country),

La

12-MAIDEN NAME OF MOTHER

Violet Milligan

13-BIRTHPLACE OF MOTHER,

(State or Country),

City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).

Mr Eugene Trusty

(Address).

1505 Apple Court

15-

FILE

JUN 4 - 1915

HARRY O. ANDREWS,

191... Serial Permit 019

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

3rd

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 22 1915, to June 3rd 1915,

that I saw her alive on May 31 1915,

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Indefinite (Duration) yrs. mos. ds.

(Signed) J. Albert Miller M. D.

June 4, 1915. (Address) 2423 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel Cem

June 4 1915

20-UNDERTAKER

ADDRESS

Peter Nicolaus

2046 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85916

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85916

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1539 N Caroline ST.: 8 WARD)

REGISTERED NO. C

2-FULL NAME Mary B. Laponville

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1539 N Caroline St.: 77 yrs., 10 mos., 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow6-DATE OF BIRTH, July 12, 1837
(Month) (Day) (Year)7-AGE, 77 yrs., 10 mos., 20 ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). Self9-BIRTHPLACE, (State or Country), Baltimore City10-NAME OF FATHER, John P. Gross11-BIRTHPLACE OF FATHER (State or Country), Pa.12-MAIDEN NAME OF MOTHER Sarah Bruner13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred Laponville(Address) 1831 Orleans St.15-JUN 4 1915 191... Burial Permit 0107
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 20th 1915, to June 1st 1915, that I saw her alive on June 1 1915, and that death occurred, on the date stated above, at 7²⁵ p m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY (Secondary) Central Apoplexy
(Duration) ... yrs. ... mos. ... ds.(Signed) George A. Medsger M. D.
June 3, 1915 (Address) 1121 N Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral CemeteryDATE OF BURIAL, June 5, 191520-UNDERTAKER Alfred C. HuberADDRESS 221 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1575 W. Fayette ST.; 19 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1575 W. Fayette St St.; 57 yrs., 9 mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED

WIDOWED,

OR DIVORCED,

(Write the word.)

married

6-DATE OF BIRTH,

August301857

(Month)

(Day)

(Year)

7-AGE,

5794

It LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

Penn

10-NAME OF FATHER,

Jos Jenkins

11-BIRTHPLACE OF FATHER

(State or Country).

Pa

12-MAIDEN NAME OF MOTHER

Mrs Kate Beck

13-BIRTHPLACE OF MOTHER

(State or Country).

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. H. Berryman

(Address)

1575 W. Fayette St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June41915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 2, 1915, to date, 1915,that I saw her alive on June 30, 1915,and that death occurred, on the date stated above, at 2:10 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure(Duration) 5 yrs., — mos., — ds.

CONTRIBUTORY (Secondary)

Diabetes(Duration) 5 yrs., — mos., — ds.

(Signed)

W. H. Berryman M. D.June 4, 1915 (Address) 841 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Louisa Park Cemetery June 6, 1915.

20-UNDERTAKER

ADDRESS

W. H. Berryman 235 N. Green

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15-

Filed

JUN 5 1915

ROBERT

KRAUT

Permit Clerk

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.; *14* WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs., *2* mos. *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) *Single*

6-DATE OF BIRTH,

Feb 27th, *1915*
(Month) (Day) (Year)

7-AGE,

yrs. *3* mos. *4* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....*None*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUN 5 - 1915 ROBERT KRAUTER
Filed Serial Death Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 1st, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1st 1915, to *June 1st* 1915,that I saw him alive on *May 31st* 1915,and that death occurred, on the date stated above, at *4:30 A.M.*

The CAUSE OF DEATH* was as follows:

Malnutrition and
Malassimilation
(Duration) yrs. *2* mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Elmer G. Hall* M. D.
June 2, 1915 (Address) *1617 E. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *2* mos. *18* ds. In the State yrs. *3* mos. *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral *June 4, 1915*

20-UNDERTAKER

ADDRESS

McHale & Sons 606 Lafayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. 606 N. Bruce St. ST. 16 WARD)

FULL NAME Catherine C. Hevey

(Residence in Baltimore: No. 606 N. Bruce St. St. 16 yrs. 11 mos. 18 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 9/1896, 1
(Month) (Day) (Year)

7 AGE 18 yrs. 11 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Clerk in Dept. Store
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore City

10 NAME OF FATHER James J. Hevey

11 BIRTHPLACE OF FATHER (State or country) Boston Mass.

12 MAIDEN NAME OF MOTHER Sarah Sweeney

13 BIRTHPLACE OF MOTHER (State or country) Baltimore City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James J. Hevey

(Address) 606 N. Bruce St.

15 JUN 5 - 1915

Filed 191

ROBERT KRAUTER

Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 2nd, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from May 4, 1915, to June 2nd, 1915, that I saw her alive on both days, 1915, and that death occurred, on the date stated above, at 5-45 m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) yrs. ? mos. ? ds.
Contributory (SECONDARY) Exhaustion
(Duration) yrs. ? mos. ? ds.
(Signed) Benj. D. McEllen, M. D.
June 4th, 1915 (Address) 404 N. Payson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cathedral Cemetery

DATE OF BURIAL June 5th, 1915

20 UNDERTAKER John Herman

ADDRESS 901 Hollis St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1609 Linden Ave. ST. 14 WARD)

2-FULL NAME Sophia M. Schultheis

(Residence in Baltimore: No. 427 N. Milton Ave. St. 7 yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-STATUS: MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH Jan 18, 1847 (Month) (Day) (Year)

7-AGE 68 yrs. 4 mos. 18 ds. or min. 7 If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE (State or country) Baltimore

10-NAME OF FATHER Friedrich Radtke

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Margaretha Thielhor

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lawrence H. H. H. H. H.

(Address) 427 N. Milton Ave.

15. JUN 5 1915 ROBERT GRAHAM REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 3, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6:30 P.M. 6/3, 1915, to 8:45 P.M. 6/3, 1915, that I saw her alive on June 3, 1915, and that death occurred, on the date stated above, at 8:45 P.M. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Duration) yrs. mos. 83 hours
Contributory Respiratory Paralysis (SECONDARY) (Duration) yrs. mos. ds. 7 months

(Signed) Stanley M. Clegg M. D. 6/3, 1915 (Address) 1609 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 3 mos. 3 ds. In the State yrs. mos. ds. Where was disease contracted? If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St Paul's Lutheran Cemetery DATE OF BURIAL June 6, 1915

20-UNDERTAKER Mrs. A. Rohde 730 Fulton ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85821

28

C85921

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

1107 W Baltimore

ST.

18

WARD)

2-FULL NAME

Herman Lee Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

Residence in Baltimore: No.

1107 W Baltimore

ST.

YRS.

MOs.

DA.)

Known to Tuberculosis Bureau as Leo Ward

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Nov

9

1888

(Month)

(Day)

(Year)

7-AGE

26

YRS.

MOs.

DS.

IF LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Driver

Shoefar

9-BIRTHPLACE

(State or country)

Baltic md

10-NAME OF FATHER

Herman Ward

11-BIRTHPLACE OF FATHER

Baltic co md

(State or country)

unknown

12-MAIDEN NAME OF MOTHER

Mary E. Schmidt

13-BIRTHPLACE OF MOTHER

Baltic md

(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Ward

(Address)

1107 W Balto st

15.

JUN 5 - 1915

ROBERT J. KRAUTER,

Barial Permit Clerk,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jan

3

1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Jan 3, 1915, to Jan 5, 1915

that I saw him alive on Jan 5, 1915

and that death occurred, on the date stated above, at 1 1/2 p.m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration)

YRS.

MOs.

DS.

Contributory (SECONDARY)

Pulm. T. B.

(Duration)

YRS.

MOs.

DS.

(Signed)

F. H. Smith

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

YRS.

MOs.

DS.

In the

State

YRS.

MOs.

DS.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

June 6

1915

20-UNDERTAKER

Robt Brooks Sonco

ADDRESS

Calhoun & Hollins

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1417 E. Madison St.)

2-FULL NAME

(Residence in Baltimore: No. 1417 E. Madison

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

June 2, 1915
(Month) (Day) (Year)

7-AGE,

yrs. mos. 2 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Balto. Md.

10-NAME OF FATHER,

William Fred. Scarbath

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Marie Glivess

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm. Wm. F. C. Scarbath

(Address)

1417 E. Madison

15-JUN 5 - 1915

HARRY O. ANDREWS,

Filed

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 4th, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

June 2nd 1915 to June 4th 1915

that I saw him alive on June 4th 1915

and that death occurred on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)Signed: J. A. Jones, M. D.
(Address) 1501 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Immanuel Evangelical Lutheran Church, June 5, 1915

20-UNDERTAKER

ADDRESS

Henry Storch & Son

1301 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85923

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159
C85923

PLACE OF DEATH

CITY OF BALTIMORE (No. 1315 W. Lanvale street, ST. 16 WARD)

2-FULL NAME Samuel R. Billups,

(Residence in Baltimore: No. 1315 W. Lanvale street, St. yrs., mos., ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married, (Write the word.)

6-DATE OF BIRTH, November 13th., 1854. (Month) (Day) (Year)

7-AGE, 60 yrs., 6 mos., 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Groceryman, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia,

10-NAME OF FATHER, Christopher Billups,

11-BIRTHPLACE OF FATHER, (State or Country), Virginia,

12-MAIDEN NAME OF MOTHER, Martha H. Diggs,

13-BIRTHPLACE OF MOTHER, (State or Country), Virginia,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles W. Billups, brother,

(Address) 1315 W. Lanvale street....

15- JUN 5 1915 HARRY O. ALLEN, Registrar. Filed..... 191. Serial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 31, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gunshot wound of head, (suicide) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. Frederick Hempel, M. D. (Coroner.)

June 4, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Lorraine Cem June 6 1915

20-UNDERTAKER, ADDRESS

Wm. J. Dickerson North & Pine

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85921

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

C85921

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1069 Vine* ST. *18* WARD)

2-FULL NAME *Infant of John & Beatrice Augustus*

(Residence in Baltimore: No. *1069 Vine* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE MARRIED *Single* WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH *May 23 1915* (Month) (Day) (Year)

7-AGE *11* If LESS than 1 day, hrs., yrs. mos. ds. or min.?

8-OCCUPATION *none* (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Md*

PARENTS 10-NAME OF FATHER *John Augustus* 11-BIRTHPLACE OF FATHER (State or country) *Md* 12-MAIDEN NAME OF MOTHER *Beatrice Geyer* 13-BIRTHPLACE OF MOTHER (State or country) *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Beatrice Augustus* (Address) *1069 Vine*

15-JUN 5 - 1915

HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 3 1915* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *May 23 1915* to *June 3 1915*, that I saw h *er* alive on *June 2 1915*, and that death occurred, on the date stated above, at *9 P* m. The CAUSE OF DEATH* was as follows:

Premature Birth

Contributory (SECONDARY) *H S M Card* (Signed) *June 3 1915* [Address] *2000 S. M. D.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Mount Auburn cemetery* DATE OF BURIAL *June 4 1915*

20-UNDERTAKER *Alfred J. Freeland* ADDRESS *1144 S. M. D.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85825

C85825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *7* WARD)

2-FULL NAME

(Residence in Baltimore: No. *721 N. Spring St.* St.; *36* yrs., *3* mos., *1* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Greenman*(Address) *721 N. Spring St.*

JUN 5 - 1915

Filed..... 191.....

HARRY O. ANDREWS,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

I HEREBY CERTIFY, That I attended deceased from

May 30 1915, to *June 4* 1915.that I saw him alive on *June 4* 1915.and that death occurred, on the date stated above, at *5:00* p.m.

The CAUSE OF DEATH* was as follows:

*General arterio-sclerosis**Coronary thrombosis*
(Duration) *4* yrs., *3* mos., *1* ds.

CONTRIBUTORY (Secondary)

(Duration) *4* yrs., *3* mos., *1* ds.(Signed) *Edward J. Smith* M. D.*June 4* 1915. (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *25* yrs., *5* mos., *1* ds. In the *36* yrs., *3* mos., *1* ds. State *MD.*Where was disease contracted, if not at place of death? *721 N. Spring St.*Former or usual residence *721 N. Spring St.*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Matthews Cemetery *June 7* 1915.

20-UNDERTAKER

ADDRESS

Henry Lutz *1007 N. Bond*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85826

CERTIFICATE OF DEATH

+45 C85826

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1*)

FULL NAME

(Residence in Baltimore: No. *1*)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word)

6-DATE OF BIRTH *Feb. 24, 1868*
(Month) (Day) (Year)

7-AGE *47* yrs. *3* mos. *18* ds. or *18* min. ?
If LESS than 1 day, hrs.

8-OCCUPATION *Judge*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Ashville - Ala.*

10-NAME OF FATHER *Richmond F. Hammond*

11-BIRTHPLACE OF FATHER (State or country) *Ashville, Ala.*

12-MAIDEN NAME OF MOTHER *Mary E. Pope*

13-BIRTHPLACE OF MOTHER (State or country) *Wetumpka - Ala.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Wif. Rena Hammond*

(Address) *Attalla Ala (imp.)*

15-JUN 5 - 1915

HARRY O. ANDREWS,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 4, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 31, 1915* to *June 4, 1915* that I saw him alive on *June 4, 1915* and that death occurred, on the date stated above, at *2:45* m. The CAUSE OF DEATH* was as follows:
General carcinoma - primary prostate

Contributory (SECONDARY) *Heart failure*
(Duration) yrs. mos. ds.
(Signed) *C. F. Burnham* M. D.
June 4, 1915 (Address) *1418 E. Canton Place*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the yrs. mos. ds. State
Where was disease contracted, If not at place of death? *Mobile Ala.*
Former or usual residence *Mobile Ala.*

19-PLACE OF BURIAL OR REMOVAL *Attalla Alabama* DATE OF BURIAL *June 5, 1915*

20-UNDERTAKER *Chas. G. Black* ADDRESS *1201 W. Mulberry St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85827

CERTIFICATE OF DEATH.

126 C85827

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1530 Greenmount Ave 12 WARD

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Hahn

(Residence in Baltimore: No.

1530 Greenmount Ave

St. 80 yrs. 5 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED, Widower

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Dec 31, 1834

(Month)

(Day)

(Year)

7-AGE

80 5 3

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)...

Retired

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

William Hahn

11-BIRTHPLACE OF FATHER

(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Susan ?

13-BIRTHPLACE OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Laura V. Hubbard

(Address)

1530 Greenmount

15-

JUN 5 - 1915

HARRY O. ANDREWS,

Filed..... 191

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 4, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 24, 1915, to June 4, 1915,

that I saw him alive on June 4, 1915,

and that death occurred, on the date stated above, at 1:50 p.m.

The CAUSE OF DEATH* was as follows:

Hypertension
(Duration).....yrs. 1 mos.ds.

CONTRIBUTORY (Secondary)

Hypertension
(Duration).....yrs.mos.ds.

(Signed) J. S. H. Patten M. D.

June 4, 1915 (Address) 508 E. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore

DATE OF BURIAL,

June 6, 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E North

ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85829

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85829

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Residence in Baltimore: No.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE

(State or Country),

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Per formant)

(Address)

15-

FILED

191

HARRY O. ANDREWS,

Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH

11-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, au-

topsy, inquiry.) and that said deceased came to... death

on the day stated above.

The CAUSE OF DEATH was as follows:

General Peritonitis
caused by an accidental blow
into the abdomen.

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner.)

June 4, 1915 (Address) 1729 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the 33 yrs. 3 mos. 29 ds.

Where the disease contracted, if not at place of death?...

at Day Shore Park

Former or usual residence 2205 Hemmeman Ave.

19-PLACE OF BURIAL OR REMOVAL

Cathedral Cemetery JUN 7 5 1915

20-UNDERTAKER

Rolt L. Turner 1442 N. Bond

ADDRESS

C85830

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85830

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Mary Hospital*)FULL NAME *Ilele Haman (Haman)*Residence in Baltimore: No. *Virginia (Coan Wharf)*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *unknown*

(Month)

(Day)

(Year)

7-AGE, *10*

Yrs. Mos. ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Virginia*10-NAME OF FATHER, *unknown*11-BIRTHPLACE OF FATHER (State or Country), *Va*12-MAIDEN NAME OF MOTHER *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *From Mary Hospital Records*

(Address)

15-

JUN 5 - 1915

191

HARRY O. ANDREWS,

Baptist Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 3rd*, 1915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquiry* (Inquest, au-topsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

*Accidental Burns of**body and limbs (play with**fire)* (Duration) *3* yrs. *2* mos. *1* ds.CONTRIBUTORY *Neuritis*

(Secondary)

(Duration) *3* yrs. *2* mos. *1* ds.(Signed) *Wm. H. Savage* M. D.(Coroner.) *June 3, 1915* (Address) *1729 N. Hollins St.*

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *1* ds. In the *1* yrs. *1* mos. *1* ds. State *1* yrs. *1* mos. *1* ds.Where was disease contracted, if not at place of death? *In Virginia*Former or usual residence *14 (Coan Wharf)*19-PLACE OF BURIAL OR REMOVAL, *Coan Wharf - Va*DATE OF BURIAL, *June 5, 1915*20-UNDERTAKER, *H. Allen Fuller*ADDRESS *2012 E. North St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85831

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85831

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *1028 Leadenhall*)

ST. *23* WARD)

REGISTERED No. C

2-FULL NAME *Hannah Smith*

Residence in Baltimore: No. *1028 Leadenhall*

St. — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

II LESS than 1 day, — hrs. or — min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) *1028 Leadenhall St*

15.

JUN 5 - 1915

HARRY O. ARTHURS,

Filed

191

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 3, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 17, 191*5*, to, *June 3*, 191*5*,

that I saw *her* alive on *June 3*, 191*5*,

and that death occurred, on the date stated above, at *10:25* a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) — yrs. — mos. *17* ds

Contributory (SECONDARY)

(Duration) — yrs. — mos. *17* ds.

(Signed), *H. O. Arthurs* M. D.

June 4, 191*5* (Address) *528 Leadenhall St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Auburn *June 6*, 191*5*

20-UNDERTAKER

ADDRESS

L. E. Brown and Son *108 W. Mount St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85832

C85832

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 3 3 N. Mount St.; 15 WARD)

2-FULL NAME

Maggie Jones Hall

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 16 3 3 N. Mount St. St.: 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Col

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

married

6-DATE OF BIRTH,

6 5, 1895
(Month) (Day) (Year)

7-AGE,

20 yrs. mos. ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....

house-maid

9-BIRTHPLACE,
(State or Country),

Kalto, City

PARENTS.

10-NAME OF
FATHER,

Daniel Jones

11-BIRTHPLACE
OF FATHER
(State or Country),

Va.

12-MAIDEN NAME
OF MOTHERMiss Dorsey
Maryland13-BIRTHPLACE
OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Daniel Jones

(Address)

16 3 3 N. Mount St.

15-

JUN 5 1915

HARRY G. ANDREW,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

6 2, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
April 25 1915, to 6-1-1915,

that I saw her alive on 6, 1915,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration).....yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs. 3 mos. ds.

(Signed).....F. H. Carls M. D.

6-3-1915, (Address) 1524 Baltimore Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Zion June 5, 1915

20-UNDERTAKER

ADDRESS

Robt W. Elliott 506 East St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85833

HEALTH DEPARTMENT—CITY OF BALTIMORE

134 C85833

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1642 Mulliken ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Reside in Baltimore: No. 1642 Mulliken St St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 15, 1885
(Month) (Day) (Year)

7-AGE,

29 yrs., 11 mos., 14 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....General
(b) General nature of industry, business, or establishment in which employed (or employer).....domestic9-BIRTHPLACE,
(State or Country),Md.

10-NAME OF FATHER,

Henry Addison11-BIRTHPLACE OF FATHER
(State or Country),Md.

12-MAIDEN NAME OF MOTHER

Laura Curry13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Curry(Address) 1642 Mulliken St.

15-

JUN 5 - 1915HARRY O. ADKINS

1915

1915Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 18, 1915, to June 3, 1915,that I saw her alive on June 3, 1915,and that death occurred, on the date stated above, at 11:15 p.m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation
Cardiac degeneration
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. O. Robinson

M. D.

June 3, 1915 (Address) 111 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

LauraJune 5, 1915

20-UNDERTAKER

ADDRESS

Robert A. Elliott 506 Rogers

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85834

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85834

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married* (Write the word)

6-DATE OF BIRTH *Unknown*, 1896 (Month) (Day) (Year)

7-AGE *19* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *Waitress.* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Maryland*

10-NAME OF FATHER *John Russell*

11-BIRTHPLACE OF FATHER (State or country) *Maryland*

12-MAIDEN NAME OF MOTHER *Mary Burke*

13-BIRTHPLACE OF MOTHER (State or country) *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Arthur Bowens*

(Address) *154 Dolphin St.*

15-JUN 5 1915 HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 3*, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *May 8*, 1915, to *June 3*, 1915, that I saw her alive on *June 1st*, 1915, and that death occurred, on the date stated above, at *9:30 A* m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory (SECONDARY)

(Signed) *J. W. Keown* M. D. *June 4th*, 1915 (Address) *1938 Linden Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Laurel Cemetery DATE OF BURIAL *June 5th*, 1915

20-UNDERTAKER

John A. Bishop ADDRESS *517 Robert St.*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85835

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91

C85835

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *2*)

WARD)

2-FULL NAME *Marie Phillips*

(If death occurred in a hospital or institution, give the NAME instead of street and number and RN out No. 12.)

Residence in Baltimore: No. *410 S. Duncan St.* St.; *1* yrs. *1* mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *white* 5-SINGLE *single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *April 29, 1914*
(Month) (Day) (Year)

7-AGE *1* yrs. *1* mos. *6* ds. or min. *?* If LESS than 1 day, hrs.

8-OCCUPATION
(a) Trade, profession or particular kind of work *child*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Maryland*

10-NAME OF FATHER *George Phillips*

11-BIRTHPLACE OF FATHER (State or country) *Md.*

12-MAIDEN NAME OF MOTHER *Jennie Deval*

13-BIRTHPLACE OF MOTHER (State or country) *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. O. Curry*

(Address) *410 S. Duncan St.*

15-
JUN 5 - 1915 HARRY O. ANDREWS,
Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 4, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 3, 1915* to *June 4, 1915*, that I saw her alive on *June 4, 1915*, and that death occurred, on the date stated above, at *3:30 p.m.*

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) yrs. mos. *6* ds.

Contributory (SECONDARY) *none*

(Signed) *John H. Hoop* M. D.
June 1915 [Address] *410 S. Duncan St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *2* In the 1 yrs. 1 mos. *6* ds. State

Where was disease contracted, If not at place of death?

Former or usual residence *410 S. Duncan St.*

19-PLACE OF BURIAL OR REMOVAL *Baltimore City* DATE OF BURIAL *June 6, 1915*

20-UNDERTAKER *A. Vander Pong* ADDRESS *1700 Fleet St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85836

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hospital* 7 WARD)

REGISTERED NO. (

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *925 E. Baltimore*

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) *single*

6-DATE OF BIRTH.

June 3, 1915
(Month) (Day) (Year)

7-AGE.

If LESS than 1 day.
... yrs. ... mos. ... ds. ... hrs. or 15 min. f

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE.
(State or Country),*Ind.*

PARENTS.

16-NAME OF FATHER,

*Solomon Horton*11-BIRTHPLACE OF FATHER
(State or Country),*Prussia*

12-MAIDEN NAME OF MOTHER

*Rose Barthel*13-BIRTHPLACE OF MOTHER
(State or Country),*Prussia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Lewis*(Address) *1419 E. Pratt*

15-

JUN 5 - 1915

HARRY O. ANDREWS,
Burial Permit Clerk...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH,

June 3, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 3, 1915, to June 3, 1915.*that I saw him alive on *June 3, 1915.*and that death occurred, on the date stated above, at *2 P. m.*

The CAUSE OF DEATH* was as follows:

Pneumonia, 7 months.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *C. P. Glass* M. D.*June 3, 1915* (Address) *J. H. Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Heaven Mt Cemetery June 5, 1915.

20-UNDERTAKER

ADDRESS

Jack Lewis 1419 E. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 085837

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hospital* ST. *7* WARD)

2-FULL NAME

(Residence in Baltimore: No. *923 E. Baltimore* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR SEPARATED.
(Write the word.)*single*

6-DATE OF BIRTH,

June 3, 1915
(Month) (Day) (Year)

7-AGE,

— yrs. — mos. — ds.

8-LESS than 1 day.

8 hrs. or — min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Ind.*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country), *Russia*

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry*(Address) *1419 E. Baltimore*

15-

JUN 5 1915

HARRY O. ANDREWS,

191. Burial Permit Officer Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *June 3, 1915*, to *June 3, 1915*, that I saw him alive on *June 3, 1915*, and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH* was as follows:

Pneumonia, 7 months
(Duration)..... yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *E. D. Glass, M. D.**June 3, 1915*. (Address) *J. H. Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Hebrew Cemetery

DATE OF BURIAL,

June 5, 1915

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85839

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *901 Rutland Ave* ST. *7* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *901 Rutland Ave* St.; *75* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>female</i>	4-COLOR OR RACE, <i>white</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>widowed</i>
6-DATE OF BIRTH, <i>May 26, 1872</i> (Month) (Day) (Year)		
7-AGE <i>42</i> yrs. <i>10</i> mos. <i>10</i> ds. If LESS than 1 day, ... hrs. or ... min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work... <i>Nurse</i> (b) General nature of industry, business, or establishment in which employed (or employer).....		
9-BIRTHPLACE, (State or Country), <i>Germany</i>		
PARENTS.	10-NAME OF FATHER, <i>Jos. Kaufman</i>	
	11-BIRTHPLACE OF FATHER, (State or Country), <i>Germany</i>	
	12-MAIDEN NAME OF MOTHER, <i>Henriette Schiff</i>	
	13-BIRTHPLACE OF MOTHER, (State or Country), <i>Germany</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Helen Kattory*
(Address) *1612 Westwood Ave*15- *HARRY O. ANDERSON*,
Filed JUN 6 1915 *Bureau of Health*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 5, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
May 1st 1915, to *June 4* 1915,
that I saw her alive on *June 4* 1915,
and that death occurred, on the date stated above, at *3 P* m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of the Lungs(Duration) *1* yrs. *10* mos. *10* ds.CONTRIBUTORY *General Metastases*
(Secondary)(Duration) *1* yrs. *10* mos. *10* ds.(Signed) *Wm. H. Savage* M. D.*June 5, 1915* (Address) *1729 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *10* mos. *10* ds. In the State *1* yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Helen Kattory *June 7, 1915*

DATE OF BURIAL

20-UNDERTAKER

Charles J. ... *118 N. ...*

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85840

C85840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No.

St.:

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....

191.....

HARRY C. ARDREWS,
Baptist Minister, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

June 4, 1915, to June 5, 1915,

that I saw him alive on June 5, 1915,

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease
& Myocarditis. Chronic
Asphyxia. Arteriosclerosis.
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Lungs. (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Hebrew Washington Rd June 6, 1915.

20-UNDERTAKER

ADDRESS

Jack Lewis 1419 E. 3rd St.

Cause of Death in plain terms is that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85841

HEALTH DEPARTMENT—CITY OF BALTIMORE

80

C85841

CERTIFICATE OF DEATH

1. PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE (No.

WARD)

2. FULL NAME

(Residence in Baltimore: No.

Sr. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH

7. AGE

If LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

JUN 6 - 1915

Filed

HARRY O. ANDREWS,

Funeral Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on
and that death occurred, on the date stated above, at 4:50 p.m.
The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *108 S. Caroline* ST.: *3* WARD)

2-FULL NAME

(Residence in Baltimore: No. *108 S. Caroline* St.: — yrs. — mos. *3* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

June 3, 1915
(Month) (Day) (Year)

7-AGE,

3 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),*Baltimore*

PARENTS.

10-NAME OF FATHER,

Charles Goodgal

11-BIRTHPLACE OF FATHER

(State or Country), *Russia*

12-MAIDEN NAME OF MOTHER

Sarah Wilkins

13-BIRTHPLACE OF MOTHER

(State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles Goodgal*(Address) *108 S. Caroline St.*

15-

Filed

JUN 6 - 1915

HARRY O. APPELBY,

191. *Bar 1st. Permit. Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 6, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 5, 1915, to June 6, 1915.*that I saw him alive on *June 5, 1915,*and that death occurred, on the date stated above, at *2 P. m.*

The CAUSE OF DEATH* was as follows:

Branchio-pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *R. A. Michelson, M. D.**June 6, 1915* (Address) *1420 S. Balto. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Bellevue Mt. Cemetery

DATE OF BURIAL,

June 6, 1915

20-UNDERTAKER

J. Levinson & Bro

ADDRESS

1107 E. Balto. St.

Specimen of death in pain, to that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85843

C85843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1019 W Langle* ST. *16* WARD)FULL NAME *Sum B. T. Brown*(Residence in Baltimore: No. *1019 W Langle St* St. *50* yrs., *—* mos. *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH

May 7th, *1885*
(Month) (Day) (Year)

7-AGE,

40 yrs. *—* mos. *28* ds. If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.

(State or Country)

West Virginia

10-NAME OF FATHER

Dr. W. H. R. Hall

11-BIRTHPLACE OF FATHER

(State or Country)

West Virginia

12-MAIDEN NAME OF MOTHER

Eliz Biscoe

13-BIRTHPLACE OF MOTHER

(State or Country)

West Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Miss Eliz Brown
(Address) *1019 W Langle St*

15-

JUN 6 - 1915

HARRY O. ANDREWS,

Filed..... 191... *Burial Permit* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 4th, *1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 1, *1915*, to *June 4*, *1915*,that I saw her alive on *June 3*, *1915*,and that death occurred, on the date stated above, at *6:15* a.m.

The CAUSE OF DEATH* was as follows:

*Fall down steps caused injury to spine
& nervous prostration
(accidental)*(Duration) *7* yrs. *—* mos. *—* ds.CONTRIBUTORY *Intoxication* - *?*
(Secondary)*Ephedrine* (Duration) *—* yrs. *—* mos. *—* ds.(Signed) *W. H. Hall* M. D.*June 5, 1915* (Address) *Int. Bureau**State the DISEASE CAUSING DEATH, or, in deaths from *Violent Causes*, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Delmar Ridge Forest, *1915*.

UNDERTAKER

ADDRESS

W. J. Suber *Public**Ames*

Values of deaths in print form, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C85844

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *121 Albemarle* ST. *3* WARD)

FULL NAME *Abraham Stiegel*

(Residence in Baltimore: No. *121 Albemarle* St.: yrs. *9* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(If write the word)

Child

6 DATE OF BIRTH

October

1914

(Month)

(Day)

(Year)

7 AGE

9

mos.

ds.

If LESS than 1 day,hrs.

ormin.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9 BIRTHPLACE

(State or country)

Balti

10 NAME OF FATHER

Hyman Stiegel

11 BIRTHPLACE OF FATHER

(State or country)

Russian

12 MAIDEN NAME OF MOTHER

Russin

13 BIRTHPLACE OF MOTHER

(State or country)

Russian

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Heur's

(Address)

1419 E. Baltz

15

JUN 6 - 1915

Filed

HARRY O. ANDREWS,

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 6th

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 4th, 1915, to June 5, 1915,

that I saw *him* alive on *June 5th, 1915,*

and that death occurred, on the date stated above, at *7 9 m.*

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(Duration) yrs. mos. ds.

2

Contributory (SECONDARY)

Pneumonia (Ruber)

(Signed)

M. Chedecor

M. D.

June 6, 1915 (Address) *226 N. 7th St*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Hebrew McEmel

DATE OF BURIAL

June 6, 1915

20 UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Baltz

12.11.15

C85845

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85845

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 E. Montgomery ST.; 22 WARD)

REGISTERED NO. C

2-FULL NAME

William Henry Thompson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 507 E. Montgomery St.; yrs. mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) single

6-DATE OF BIRTH,

May 14, 1915

7-AGE,

21 yrs. mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. not any.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John S. Thompson

(Address) 507 E. Cross St.

15-

JUN 6 - 1915.

HARRY O. ANDREWS,

Filed

181 Central Bldg. 01915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 5, 1915

I HEREBY CERTIFY, That I attended deceased from May 14, 1915, to June 5, 1915, that I saw him alive on June 4, 1915, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

CONTRIBUTORY (Secondary)

(Signed) D. S. Rustin

June 5, 1915. (Address) 301 E. Cross St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery June 7, 1915

20-UNDERTAKER

ADDRESS

F. A. Krause 703 Hanover

Check of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1425 McCulloh* ST.; *14* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

James W. Amos(Residence in Baltimore: No. *1425 McCulloh*St.: *57* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-~~STATUS~~ *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

Sept. 20th, 1857
(Month) (Day) (Year)

7-AGE.

57 yrs. *9* mos. *16* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, business,
or establishment in which
employed (or employer).....*Contractor*9-BIRTHPLACE,
(State or Country),*Balto. Md.*10-NAME OF
FATHER,*Fred A. Amos*11-BIRTHPLACE
OF FATHER
(State or Country),*Md.*12-MAIDEN NAME
OF MOTHER*Louisa Upshur*13-BIRTHPLACE
OF MOTHER
(State or Country),*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Carroll N. Amos*(Address) *1425 McCulloh Str.*

15-

JUN 6 - 1915**HARVEY P. ANDREWS,****Barber Permit Clerk**

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 4th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1st, 1915, to *June 4th, 1915*,that I saw him alive on *June 4th, 1915*
and that death occurred, on the date stated above, at *7:00* m.

The CAUSE OF DEATH* was as follows:

*Chronic Interstitial
Nephritis*CONTRIBUTORY
(Secondary)*Cerebral Apoplexy*
(Duration) yrs. mos. ds.(Signed) *H. H. Andrews* M. D.*June 5, 1915* (Address) *117 W. Calver*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Green Mount

20-UNDERTAKER

E. M. Mitchell & Co.

DATE OF BURIAL,

June 7th, 1915

ADDRESS

120 W. Fayette St.

Cause of death in plain terms, so that it may be properly understood. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85847

CERTIFICATE OF DEATH.

79 C85847
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 S. Steeper ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 624 S. SteeperSt.; 27 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Not know1858

(Month)

(Day)

(Year)

7-AGE,

57

yrs.

0

mos.

0

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

House work

(b) General nature of industry, business, or establishment in which employed (or employer)...

at home9-BIRTHPLACE,
(State or Country).German Poland.

10-NAME OF FATHER,

not know.11-BIRTHPLACE OF FATHER
(State or Country),Not know.

12-MAIDEN NAME OF MOTHER

Not know.13-BIRTHPLACE OF MOTHER
(State or Country),Not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Duis(Address) 624 S. Steeper.

JUN 6 - 1915.

DARRY O. ADAMS,

Filed..... 191... Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 51915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 3, 1915, to June 5, 1915,that I saw her alive on June 5, 1915,and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)Arteriosclerosis

(Duration).....yrs.....mos.....ds.

(Signed) R. J. Jamper M. D.June 5, 1915. (Address) 2431 Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus.

DATE OF BURIAL,

June 7, 1915.

ADDRESS

405 S. Ann

Errors of death in print terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85848

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85848

CERTIFICATE OF DEATH

1-PLACE OF DEATH

U.S. Marine Hospital

REGISTERED NO. C.

CITY OF BALTIMORE: (NO)

2-FULL NAME

Albert Pusick

(If death occurred in a hospital or institution, give its NAME instead of street and number and add No. 18.)

Residence in Baltimore: No.

U.S. Marine Hospital, 1 Year 9 Months

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Unknown, 1

7-AGE

50 yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Seaman

9-BIRTHPLACE
(State or country)

Maryland

10-NAME OF FATHER

Not known

11-BIRTHPLACE OF FATHER
(State or country)

not known

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER
(State or country)

not known.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Hospital record.

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 4, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Aug 27, 1913, to, June 4, 1915, that I saw him alive on June 4, 1915, and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Leucocythemia

(Duration) yrs. 9 mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Chas. M. Meigs, M.D.
June 5, 1915 (Address) U.S. Marine Hospital

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 1 yrs. 9 mos. In the State of Mo. ds.

Where was disease contracted? U.S. Marine Hospital

If not at place of death? U.S. Marine Hospital

19-PLACE OF BURIAL OR REMOVAL

Trinity Cemetery

DATE OF BURIAL

June 6, 1915

20-UNDERTAKER

H. E. Hughes

ADDRESS

178 Broadway

JUN 6 - 1915

Filed

191

HARRY O. ARDREWS

Marial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 641 Portland ST. 22 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Herman H. Schroeder(Residence in Baltimore: No. 641 PortlandSt. 57 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed (Write the word.)6-DATE OF BIRTH, Oct 31st, 1836 (Month) (Day) (Year)7-AGE, 78 yrs. 7 mos. 4 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, Retired (b) General nature of industry, business, or establishment in which employed (or employer), Grocer9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, Gerhart Schroeder11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER, Catherine Foenig13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman H. Nesselman(Address) 1834 N. Franklin St.

15- JUN 7 - 1915

Filed..... 191

DEPT. KRAUTER

Burial Permit Class

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 4th, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1914, to June 4, 1915, that I saw him alive on June 4, 1915 and that death occurred, on the date stated above, at 6, 1. m. The CAUSE OF DEATH* was as follows:Hypertrophy of Prostate Gland
with Hemorrhagic Cystitis
(Duration) 1 yrs. 9 mos. ds.CONTRIBUTORY Chr. Endocarditis (Secondary)(Signed) J. M. Moran M. D. June 5, 1915 (Address) 621 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore CemeteryDATE OF BURIAL, June 7, 191520-UNDERTAKER, Mrs. John H. PenfelADDRESS, 801 N. Fayette St.

Errors or omissions in plain text, so that it may be properly changed. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 10.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.,

yrs. 3 mos. 3 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 5, 1915, to June 5, 1915

that I saw him alive on June 5, 1915,

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal
Malnutrition & as to
indigestion.

(Duration)

yrs. 3 mos. ds.

Contributory
(SECONDARY)

(Duration)

yrs. 1 mos. ds.

(Signed)

B. B. Korman 6.6.1915 [Address] 3547 Chestnut

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Mary's Cemetery June 7, 1915

20-UNDERTAKER

ADDRESS

H. S. Marshall 3539 Falls Rd

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15-

JUN 7 - 1915

J. KRAUTER,

Municipal Health Clerk

REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085851

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

170

085851

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *738 W. Power St.* ST. *13* WARD)

2-FULL NAME *Joseph Tucker*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No. *738 Power St.* St. *13* yrs. *5* mos. *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Widowed*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Aug 30, 1858*
(Month) (Day) (Year)

7-AGE *58* yrs. *9* mos. *7* ds. or min. *7* If LESS than 1 day, hrs. min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *Engineer*
(b) General nature of industry, business, or establishment in which employed (or employer) *School.*

9-BIRTHPLACE
(State or country) *W. Va.*

10-NAME OF FATHER *asked not given*

11-BIRTHPLACE OF FATHER *asked not given*

12-MAIDEN NAME OF MOTHER *Amelia Pickett*

13-BIRTHPLACE OF MOTHER *W. Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Amelia Connelley*

(Address) *738 Power St.*

15

JUN 7 - 1915

Filed

DEPT. OF HEALTH
Baltimore
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 6, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 18, 1915* to *June 6, 1915*

that I saw him alive on *June 5, 1915* and that death occurred, on the date stated above, at *12 N. Ave.*

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(Indistinguishable)

Indefinite (Duration) yrs. mos. ds.

Contributory (SECONDARY) *Suppurative pneumonia*

(Signed) *R. B. Bennett* M. D.

6.6.1915 [Address] *3347 Chestnut St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Mary's St.

DATE OF BURIAL

June 8, 1915

20-UNDERTAKER

A. S. Russell

ADDRESS

3539 E. Belk

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

085852

CERTIFICATE OF DEATH

152 085852

PLACE OF DEATH

CITY OF BALTIMORE (No. 1519 Chapel

ST: 8 WARD)

2-FULL NAME Infant of John T. & Margaret Martin

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. 1519 Chapel

St.: yrs. mos. ds.) 10 minutes

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6-DATE OF BIRTH 6 5, 1915 (Month) (Day) (Year)

7-AGE If LESS than 1 day, hrs. or min. ? yrs. mos. ds.

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE (State or country) Balto Md

10-NAME OF FATHER John T. Martin

11-BIRTHPLACE OF FATHER (State or country) Balto Md

12-MAIDEN NAME OF MOTHER Margaret M. Sullivan

13-BIRTHPLACE OF MOTHER (State or country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John T. Martin

(Address) 1519 Chapel St

15. JUN 7 - 1915, ROBERT E. RAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 6 5, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1915, to June 5, 1915, that I saw her alive on June 5, 1915, and that death occurred, on the date stated above, at 6:17 PM. The CAUSE OF DEATH* was as follows:

Asphyxiation 10 min (Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) George L. Duane M.D. June 5, 1915 (Address) 721 N. Kenton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St Peter

DATE OF BURIAL June 7, 1915

20-UNDERTAKER John G. Brown

ADDRESS 901 Hollins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85853

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 C85853

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *325 S. Parrish* ST. *19* WARD)

2-FULL NAME *Bertha W. ~~Br~~ Luh (Luh)*

Residence in Baltimore: No. *325 S. Parrish*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *3* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *female* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married* (Write the word)

6-DATE OF BIRTH *Aug 8, 1895*
(Month) (Day) (Year)

7-AGE *19* yrs. *9* mos. *26* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *housewife* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore*

10-NAME OF FATHER *Ehler Brandt*

11-BIRTHPLACE OF FATHER (State or country) *Germany*

12-MAIDEN NAME OF MOTHER *Delius*

13-BIRTHPLACE OF MOTHER (State or country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Louis Luh*

(Address) *325 S. Parrish*

15-*JUN 7 - 1915* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 4, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 30, 1914* to *June 4, 1915*.

that I saw him alive on *June 4, 1915*.

and that death occurred, on the date stated above, at *12:15 P.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory (SECONDARY) *Exhaustion*

(Signed) *P. Gustafson* M. D. *June 5, 1915* (Address) *1433 W. Lombard St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Landon Park* *JUN 7 - 1915*

20-UNDERTAKER *Harry A. Witzke* ADDRESS *1531 W. Lombard*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85854

CERTIFICATE OF DEATH.

64 C85854

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

521 Franklin Terrace St.

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME

Mary Dougherty

Residence in Baltimore: No.

521 Franklin Terrace St.

40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

March 25, 1842

(Month)

(Day)

(Year)

7-AGE,

73 yrs. 2 mos. 19 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Ireland

10-NAME OF FATHER,

James Callahan

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary Callahan

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Margaret Murphy

(Address)

521 Franklin Terrace

15-

Filed.

June 7 1915

1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 5, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

1912, to June 5, 1915

that I saw her alive on June 4, 1915

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) J. M. Egan M. D.

6/6, 1915 (Address) 502 Hudson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Ave

DATE OF BURIAL,

June 8, 1915

20-UNDERTAKER

Geo. M. Fink

ADDRESS

811 N. Wolfe

STATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85855

CERTIFICATE OF DEATH.

REGISTERED NO. C

C85855

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2333 Mandamin Ave. ST.; 15 WARD)

2-FULL NAME Edward Oliver Stevens

(Residence in Baltimore: No. 2333 Mandamin Ave

St.: yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, white 5-SINGLE, single
MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, May 18th, 1915
(Month) (Day) (Year)

7-AGE, 19 yrs. 19 mos. 19 da. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), md.

10-NAME OF FATHER, Lester L. Stevens

11-BIRTHPLACE OF FATHER (State or Country), md.

12-MAIDEN NAME OF MOTHER Mabel Horn

13-BIRTHPLACE OF MOTHER (State or Country), Wash. D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lester L. Stevens

(Address) 2333 Mandamin Ave.

15- JUN 7 - 1915 Green Mount Green Mount

FILED JUN 7 - 1915 Green Mount Green Mount

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6th 1915, to June 6th 1915, that I saw him alive on June 6th 1915, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Sudden collapse following a condition of asthma due to a low vitality & poor circulation of the blood
(Duration) 19 days (Secondary) 19 days

CONTRIBUTORY low vitality since birth
(Duration) 19 days

(Signed) Salmon A. Kessinger M. D.
June 7th, 1915. (Address) 21 W. Mt. Royal Ave.

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Green Mount June 7th, 1915.

20-UNDERTAKER ADDRESS E. M. Mitchell & Co. 1200 Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 Edmondson Ave. ST. 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie S. Jordan(Residence in Baltimore: No. 1113 Edmondson Ave.

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White5-~~SEX~~ MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Married

6-DATE OF BIRTH,

April 10th, 1876
(Month) (Day) (Year)

7-AGE,

39 yrs. 2 mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none9-BIRTHPLACE,
(State or Country),Alex. Va.

PARENTS.

10-NAME OF FATHER,

James E. Green11-BIRTHPLACE OF FATHER
(State or Country).Va.

12-MAIDEN NAME OF MOTHER

Anna S. Harris13-BIRTHPLACE OF MOTHER
(State or Country).Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Herbert R. Jordan

(Address)

1113 Edmondson Ave.

15-

ROBERT J. TRAUTMAN

FILED

JUN 7 - 1915Serial Permit Office

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 6, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 4 1915, to June 6 1915,

that I saw her alive on

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Coronary
Artery
Obstruction

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Arteriosclerosis
of
Arteries

(Duration) yrs. mos. ds.

(Signed) C. A. Trautman M. D.6/6, 1915 (Address) 605

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SELF-KILLED, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Green ParkJune 8, 1915

20-UNDERTAKER

E. M. Mitchell & Co.

ADDRESS

129 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No.

FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St.; yrs.; mos.; ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE,

MARRIED,

OR DIVORCED.

(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FED.

COURT

KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

The CAUSE OF DEATH* was as follows:

Acute Pulmonary
Edema (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arterio-sclerosis (Duration) yrs. mos. ds.

(Signed) Elmer Newman, M. D.

June 7, 1915 (Address) 212 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85858

C85858

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.

427 N High

ST.;

5

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

Carrie Feige

(Residence in Baltimore: No.

427 N. High

St.

34

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH

April

18

1898

(Month)

(Day)

(Year)

7-AGE

37

yrs.

1

mos.

16

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Midwife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Balto Co Md

10-NAME OF FATHER,

George Seinger

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

John P Feige

(Address)...

2444 McCulloch st

15-

ROBERT KRAUTH

Filed

JUN 7 - 1915

Burial Permit 01

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June

5

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 5th 1915 to June 5th 1915that I saw her alive on June 5th 1915

and that death occurred, on the date stated above, at 120 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis, and
Nervous Break Down

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

Cerebral Apoplexy

(Duration)

yrs.

mos.

ds.

(Signed) ... M. D.

June 5th 1915 (Address) 607 N Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

June 8th, 1915

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E Monument

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2401 E Hoffman ST.; 8 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 2401 E Hoffman St.; 69 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Widow

6-DATE OF BIRTH

October 15th, 1840
(Month) (Day) (Year)

7-AGE

74 yrs., 7 mos., 23 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife9-BIRTHPLACE,
(State or Country),Birmingham England

10-NAME OF FATHER,

Unknown11-BIRTHPLACE OF FATHER
(State or Country),England

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur J. Wonderly(Address) 1413 N. Patterson Pl. and

15-

JUN 7 - 1915

Filed

ROBERT E. BRATTONBurial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 7, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from June 7, 1915, to June 7, 1915, that I saw her alive on June 7, 1915, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) 6 yrs., 6 mos., ds.CONTRIBUTORY (Secondary) Arterio Sclerosis(Duration) 1 yrs., mos., ds.(Signed) J. E. Hooper M. D.June 7, 1915 (Address) 1301 N. Patterson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

June 9th, 1915

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Main

Specimen of death certificate in plain form, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

180 C85860
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Community Hospital* T. *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *827 W. Lombard St.* St.: *15* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widowed

6-DATE OF BIRTH,

unknown, *1853*
(Month) (Day) (Year)

7-AGE,

*62*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Tailor*

9-BIRTHPLACE, (State or Country),

Austria

10-NAME OF FATHER,

Louis Wurtzel

11-BIRTHPLACE OF FATHER (State or Country),

Austria

12-MAIDEN NAME OF MOTHER

P.

13-BIRTHPLACE OF MOTHER (State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

The Registrar
827 W. Lombard St.

15-

*JUN 7 - 1915**HEART DISEASE**Funeral Permit*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 6, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 6, 1915, to *June 6, 1915*that I saw him alive on *June 6, 1915*,and that death occurred, on the date stated above, at *7:30 p.m.*

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis(Duration) *2 yrs.* *History* mos. ds.

CONTRIBUTORY (Secondary)

(Duration) *8 yrs.* mos. ds.(Signed) *B. H. Thierstein* M. D.*June 4, 1915* (Address) *Community Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *Balt.*Former or usual residence *827 W. Lombard St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Mary's Hospital**June 7, 1915*

20-UNDERTAKER

ADDRESS

*S. Linsome Pro**Baltimore*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2823 Guilford Ave.* ST.; *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME *Louis M. Watter*Residence in Baltimore: No. *2823 Guilford Ave.* St.; *28* yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

56 yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None X9-BIRTHPLACE,
(State or Country),*Russia*

PARENTS.

10-NAME OF FATHER,

Lazarus Watter

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. H. Denison

(Address)

1026 E Pratt St

15-

Filed

JUN 7 - 1915

191

OFFICIAL RECORD CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June *6*, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 20 191*4* to *June 6* 191*5*that I saw him alive on *June 6* 191*5*,and that death occurred, on the date stated above, at *10:30* m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. — mos. — ds.

(Signed) *L. H. Davis* M. D.*June 7*, 191*5* (Address) *928 N. Connelley St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Debrau Ferring Run

20-UNDERTAKER

*S. Turner & Co**Baltimore*

DATE OF BURIAL,

June 7, 191*5*ADDRESS *1107 E**Baltimore*

School or business in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 St Paul ST.; 11 WARD)

2-FULL NAME

Frederick Home Hack(Residence in Baltimore: No. 1211 St Paul St.; yrs., mos. ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

November 22, 1846
(Month) (Day) (Year)

7-AGE,

68 yrs. 6 mos. 13 ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Attorney at Law9-BIRTHPLACE,
(State or Country),Baltimore Md.

PARENTS.

10-NAME OF FATHER,

Frederick A. Hack11-BIRTHPLACE OF FATHER
(State or Country),Baltimore Md.

12-MAIDEN NAME OF MOTHER

Anna M. Rieman13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Newcomer Hack(Address) 1211 St Paul St.

15-

JUN 7 - 1915

Filed.....

191.....

ROBERT KRAUTH1211 St Paul St.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 5, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Dec 15 1914, to June 5 1915,that I saw him alive on June 4 1915,and that death occurred, on the date stated above, at 12²² A m.

The CAUSE OF DEATH* was as follows:

Mitral Heart Disease
Myocarditis, double heart
(Duration)..... yrs. mos. ds.CONTRIBUTORY
(Secondary)Chronic Nephritis
(Duration)..... yrs. mos. ds.

(Signed).....

John F. Anderson M. D.
June 6, 1915 (Address) 1013 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Breunmann

DATE OF BURIAL,

June 7, 1915

20-UNDERTAKER

Henry W. Jackson 1013 N. Charles St.
Richard
etc.

School of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85863

CERTIFICATE OF DEATH.

C85863

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Josephs Hospital* ST.; *11* WARD)

2-FULL NAME

Residence in Baltimore: No. *6 W Larnvale* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Don't know, 1 (Month) (Day) (Year)

7-AGE,

70

yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Butler

9-BIRTHPLACE, (State or Country),

Alexander Va

10-NAME OF FATHER,

Don't know

11-BIRTHPLACE OF FATHER (State or Country),

Va

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER (State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *G. R. Leffendeller*(Address) *102 ...*

15-

JUN 7 - 1915

NOTARY . KRAUTER,

Filed ... 191 ... REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 5, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 24 1915, to *June 5* 1915,that I saw him alive on *June 5* 1915,and that death occurred, on the date stated above, at *7:45 P.* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) *6* yrs. *6* mos. *6* ds.

CONTRIBUTORY (Secondary)

Myocarditis(Signed) *J. H. Warner* M. D.*Jan. 6., 1915.* (Address) *St. Josephs Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *15* ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? *6 W Larnvale*Former or usual residence *6 W Larnvale*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Josephs Hospital**June 8., 1915.*

20-UNDERTAKER

ADDRESS

*William Cook**502 ...*

Save this certificate in your home, so that it may be properly claimed. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85864

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

151

C85864

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2405 Edmondson Ave* WARD *20*)

2-FULL NAME

John Hegar

(Residence in Baltimore: No. *2405 Edmondson Ave* St. yrs. mos. *2* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

June 6, 1915
(Month) (Day) (Year)

7-AGE

2 yrs. *2* mos. *2* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Baltimore

10-NAME OF FATHER

Alfred Hegar

11-BIRTHPLACE OF FATHER (State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Carrie Burgess

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alfred Hegar

(Address)

2405 Edmondson Ave

15-

JUN 7 - 1915

Filed

191

ROBERT K. BRADY, Registrar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 6, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 4, 1915 to *June 6, 1915*

that I saw him alive on *June 6, 1915*

and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH* was as follows:

*Premature Birth
6 Months Gestation*

(Duration) yrs. mos. *2* ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *John T. Spickard* M. D.
2112 E. Belle St.
191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

June 7, 1915

20-UNDERTAKER

Chas E. Francis

ADDRESS

802 Madison

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1)

2-FULL NAME

(Residence in Baltimore: No. 3100 E. Hamburg, St.; yrs., mo., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER.

(State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER.

(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed.

JUN 7 - 1915

ROBERT KRAUTH

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 2:28 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 2 mos. ds.

(Signed)

6/6/15, 1915. (Address) Franklin St. No. 3100 E. Hamburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. 2 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 300 E. Hamburg St.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Cross A.C. Co.

June 8, 1915.

20-UNDERTAKER

ADDRESS

E. B. Harle

115 E. N. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE. <i>Col</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <i>Single</i>
6-DATE OF BIRTH. <i>May 15, 1915</i> (Month) (Day) (Year)		
7-AGE. <i>13</i> yrs. mos. ds.		It LESS than 1 day,hrs. or....min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		
<i>None</i>		
9-BIRTHPLACE. (State or Country), <i>Baeto</i>		
PARENTS.	10-NAME OF FATHER. <i>Wm E Sewell</i>	
	11-BIRTHPLACE OF FATHER (State or Country). <i>Ind</i>	
	12-MAIDEN NAME OF MOTHER <i>Mary Clements</i>	
	13-BIRTHPLACE OF MOTHER (State or Country). <i>Ind</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-*JUN 7 - 1915.*

Filed, 191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry, and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner.)

May 28, 1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

PUBLIC CEMETERY

JUN 4 - 1915

20-UNDERTAKER

ADDRESS

Commissioner Health

Every item of information should be carefully supplied. All should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85867

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 C85867

PLACE OF DEATH

CITY OF BALTIMORE (No. *Frank of Caroline* ST. *3* WARD)

FULL NAME

Residence in Baltimore: No. *Not Known*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Not Known*

6-DATE OF BIRTH, *Not Known*, 1 (Month) (Day) (Year)

7-AGE, *30* yrs. *-* mos. *-* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Not Known*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Not Known*

10-NAME OF FATHER, *Not Known*

11-BIRTHPLACE OF FATHER (State or Country), *Not Known*

12-MAIDEN NAME OF MOTHER, *Not Known*

13-BIRTHPLACE OF MOTHER (State or Country), *Not Known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JUN 7 - 1915

Filed. JUN 7 - 1915

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May* *31*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

And that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) *John Jones* M. D. (Coroner.)

June 3rd 1915 (Address) *3116 O'Donnell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY DATE OF BURIAL, JUN 4 - 1915

20-UNDERTAKER, Commissioner Hall, ADDRESS

per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85868

PLACE OF DEATH

CERTIFICATE OF DEATH.

152

C85868

REGISTERED No. C.

CITY OF BALTIMORE (No. 508 V. Spring

2-FULL NAME 10 name.

St.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 508 V. Spring

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, Colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 26, 1915
(Month) (Day) (Year)

7-AGE, If LESS than 1 day, yrs. or (in min.)

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Samuel G. Proctor

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Gertrude Gouge

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel G. Proctor

(Address) 508 V. Spring St

15-JUN 7 - 1915

Filed. 191. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Strangulation at birth. No one attended.
child illegitimate
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Signed) Dr. Jones
May 26, 1915 (Address) 316 Oxford St
(Coroner) M. O.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. In the State. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY

20-UNDERTAKER, Commissioner Health

DATE OF BURIAL, JUN 7 - 1915

ADDRESS

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Balto City & Car Hop*)

2-FULL NAME

(Residence in Baltimore: No. *Unknown*)

REGISTERED No. C

St. *3* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Unknown*

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

50 about
yrs. mos. ds.

If LESS than 1 day.
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE, (State or Country),

Italy (Innocent)

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUN 7 - 1915

Filed..... 191

W. KRAUTER
Funeral Home

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 26, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-

..... and that said deceased came to..... death
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Meinert's
(Explosion of Dynamite)
(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Unknown
(Duration)..... yrs. mos. ds.

(Signed).....

M. D.
(Coroner.)

June 4, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the..... State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

PUBLIC CEMETERY

DATE OF BURIAL

JUN 4 - 1915

20-UNDERTAKER

Commissioner Health.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Duplicate

085870

HEALTH DEPARTMENT—CITY OF BALTIMORE

085870

CERTIFICATE OF DEATH.

x175

PLACE OF DEATH *University Hospital*
CITY OF BALTIMORE (No. *St.* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *John Schmidt*
(Residence in Baltimore No. *Unknown (Carter Bay or Wagner's Pl.)* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *male* 4-COLOR OR RACE *W.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Unknown*
6-DATE OF BIRTH, *Unknown*, 1 (Month) (Day) (Year)
7-AGE, *about 55* If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Laborer* (b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), *Unknown*
10-NAME OF FATHER, *Unknown*
11-BIRTHPLACE OF FATHER (State or Country), *Unknown*
12-MAIDEN NAME OF MOTHER, *Unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Information from Hospital*
(Address)

15-JUN 7 - 1915 ROBERT KRAUTER, Registrar.
Filed..... 191. *Car 1st. Death*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 19, 1915*
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)
hereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.)
And that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Shock from accidental injury (amputation of both legs) the result of being struck & run over by a railroad car.
Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.
(Signed) *Wm. H. Savage*, M. D. (Coroner.)
June 3rd 1915 (Address) *1729 Madison Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-SIENTS, OR RECENT RESIDENTS).
At place of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY. DATE OF BURIAL, JUN 4 - 1915
20-UNDERTAKER *Commissioner Health* ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085871 HEALTH DEPARTMENT—CITY OF BALTIMORE 085871
CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *Pennamond dead Mary Hospital* ST. 4 WARD) REGISTERED NO. C
FULL NAME *John Hughes*
(Residence in Baltimore: No. *612 Water St* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Male</i>	4-COLOR OR RACE <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <i>1</i>
6-DATE OF BIRTH,, 1..... (Month) (Day) (Year)		
7-AGE, <i>about 70</i> yrs. mos. ds.		It LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer)..... <i>Yalover</i>		
9-BIRTHPLACE, (State or Country), <i>1</i>		
PARENTS.	10-NAME OF FATHER, <i>7</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>7</i>	
	12-MAIDEN NAME OF MOTHER <i>7</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>7</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Police records*
(Address)

15- *JUN 7 - 1915*
Filed..... 191.....
Registrrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,
May 13, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, au- topsy or inquiry.) And that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Accident - Fractured skull. Fell down cellar stairs at 612 Water St.
(Duration) yrs. mos. ds.
CONTRIBUTORY *Alcoholism* (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Photo Chambers* M. D. (Coroner)
May 24, 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.
Where was disease contracted, if not at place of death.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *PUBLIC CEMETERY*
DATE OF BURIAL *JUN 7 1915*
20-UNDERTAKER *Commissioner Health*
ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85872

HEALTH DEPARTMENT--CITY OF BALTIMORE

43

C85872

CERTIFICATE OF DEATH

1-PLACE OF DEATH

607 N. Carrollton

REGISTERED NO. C

CITY OF BALTIMORE (No.

607 N. Carrollton

ST.

16

WARD)

2-FULL NAME

Amelia K. Horack

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

(Residence in Baltimore: No.

607 N. Carrollton

St.

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

6-DATE OF BIRTH

4

21

1841

(Month)

(Day)

(Year)

7-AGE

74

yrs.

1

mos.

13

ds.

If LESS than
1 day,hrs.
ormin.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE

(State or country)

md.

10-NAME OF FATHER

Wm A. Hammerer

PARENTS

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Wilhelmina

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John K. Horack

(Address)

607 N. Carrollton

15

Filed

JUN 7 - 1915

ROBERT K. KRAUTER

Chief Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

4

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1

1915

to

June 4

1915

that I saw him alive on June 4, 1915,

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma excised in 1911
(Left breast)

(Duration)

5

yrs.

mos.

ds.

Contributory
(SECONDARY)

Pleurisy - left side - and
myocarditis

(Duration)

5

yrs.

mos.

ds.

(Signed)

G. L. Daneyhue

M. D.

June 5, 1915

(Address)

403 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Ave.

DATE OF BURIAL

June 7, 1915

20-UNDERTAKER

W. M. Monteau

ADDRESS

230 N. Green

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C.

CITY OF BALTIMORE: (No. 1707 Bruce St.; 15 WARD)2-FULL NAME Eva Parker

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1707 Bruce St.; yrs. mos. (ls.))

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE Caucasian 5-SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)6-DATE OF BIRTH Unknown 1898 (Month) (Day) (Year)7-AGE 17 yrs. mos. ds. or min. If LESS than 1 day, hrs.8-OCCUPATION (a) Trade, profession or particular kind of work School girl (b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE (State or country) Baltimore Md10-NAME OF FATHER Thomas Parker11-BIRTHPLACE OF FATHER (State or country) Md12-MAIDEN NAME OF MOTHER Ella Rogers13-BIRTHPLACE OF MOTHER (State or country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Rogers(Address) 1707 Bruce St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 5, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 22, 1915, to, June 5, 1915, that I saw her alive on June 5, 1915, and that death occurred, on the date stated above, at 4:30 p.m. The CAUSE OF DEATH* was as follows:Acute Valvular Heart DiseaseContributory (SECONDARY) Cardiac Asthenia (Duration) yrs. mos. ds.(Signed) E. William T. Lee M. D. June 6, 1915 [Address] 1428 Penna Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL - DATE OF BURIAL

Charmey Station June 9, 191520-UNDERTAKER BaltimoreJames H. Dennis 1303 Pennsylvania

15- JUN 7 - 1915. ROBERT KRAUTER, REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *Mercy Hospital* ST. *15* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John Bailey*(Residence in Baltimore: No. *1368 Stricker St.* St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE *Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) *Widowed*6-DATE OF BIRTH, *July 12, 1873*

(Month)

(Day)

(Year)

7-AGE, *41* yrs. *10* mos. *23* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Stableman*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *James Bailey*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER *Fancis Primrose*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George Henry Hoop*(Address) *Calvert St.*

15-

Filed *JUN 7 - 1915**ROBERT KRAUTER*
Burial Permit Office

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 5, 1915*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *May 21, 1915*, to *June 5, 1915*, that I saw him alive on *June 5, 1915*, and that death occurred, on the date stated above, at *7:30 p.m.*

The CAUSE OF DEATH* was as follows:

Chronic Paroxysmal Atherosclerosis
Do not know

CONTRIBUTORY (Secondary)

(Duration) *15* yrs. *10* mos. *23* ds.(Signed) *Edward J. Smith* M. D.*June 5, 1915* (Address) *Mary Hop*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *15* yrs. *10* mos. *23* ds. In the *15* yrs. *10* mos. *23* ds. State *15* yrs. *10* mos. *23* ds.Where was disease contracted, if not at place of death? *1368 Stricker St.*Former or usual residence *1368 Stricker St.*19-PLACE OF BURIAL OR REMOVAL, *Wt. Auburn*DATE OF BURIAL, *June 9, 1915*

20-UNDERTAKER

ADDRESS

James H. Dennis *303 Chestnut*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mon., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THIS ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....

JUN 7 - 1915.

ROBERT JOHNS HOPKINS HOSPITAL.

20-UNDERTAKER

Commissioner Health.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 4, 1915.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 11, 1915, to June 4, 1915,

that I saw him alive on June 4, 1915,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs., 2 mos., 2 ds.

CONTRIBUTORY (Secondary)

(Duration) 4 yrs., 4 mos., 4 ds.

(Signed) J. Winton Cliff, M. D.

June 4, 1915. (Address) St. Joseph's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 24 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

JUN 4 - 1915

ADDRESS

FOR ANATOMICAL PURPOSES.

important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85876

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 C85876

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST. 14 WARD)

2-FULL NAME Beatrice Johnson

(Residence in Baltimore: No. 648 Smith Str St.; yrs. mos. ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Col

5-SINGLE

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

Sept.
(Month)

1
(Day)

1910
(Year)

7-AGE

4
yrs.

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

md.

10-NAME OF FATHER

Wallace Johnson

11-BIRTHPLACE OF FATHER
(State or country)

md.

12-MAIDEN NAME OF MOTHER

Augusta Davis

13-BIRTHPLACE OF MOTHER
(State or country)

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. O. Phelps

(Address)

Johns Hopkins Hosp

15- JUN 7 - 1915

Filed....., 191

ROBERT KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June
(Month)

5
(Day)

1915
(Year)

I HEREBY CERTIFY, That I attended deceased from May 28, 1915, to June 5, 1915, that I saw her alive on June 5, 1915, and that death occurred, on the date stated above, at 3:55 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration)

3 yrs.

3 mos.

 ds.

Contributory (SECONDARY)

Pulmonary Tuberculosis

(Duration)

10 yrs.

1 mos.

 ds.

(Signed),

Oliver S. Rothhol

M.D.

June 1, 1915

(Address)

Johns Hopkins Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs. 9 mos. ds.

State.....yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 648 Smith St.

19-PLACE OF BURIAL OR REMOVAL

St. Ambrose

DATE OF BURIAL

6/8, 1915

20-UNDERTAKER

Sam'l T. Newby

ADDRESS

578 N. Bridge

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85877

119 C85877

PLACE OF DEATH

CITY OF BALTIMORE (No. 2128 Stuy

ST. 14 WARD)

2-FULL NAME

Mary Wake (Wake)

(Residence in Baltimore: No. 2128 Stuy

St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female Colored

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6-DATE OF BIRTH

Unknown, 1862

7-AGE

53

Yrs. mos. ds. or min.?

If LESS than 1-day, hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE (State or country)

Maryland

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER (State or country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Oscar Wake

(Address)

501 Beunes

JUN 7 - 1915

Filed 1915

JOSEPH H. TRAUTER,

Official Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

6-4-1915

17-I HEREBY CERTIFY. That I attended deceased from

5-17-1915 to 6-4-1915

that I saw her alive on 6-4-1915

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Re Nephritis & Uremia

Contributory (SECONDARY)

Uremia

(Signed)

B. B. Rhett M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McBride

6-7-1915

20-UNDERTAKER

ADDRESS

Sam'l D. Dwyer 578 N. Biddle

state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

C85878

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 92 C85878

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hosp*) ST. *7*

REGISTERED No. C.....

2-FULL NAME *Ann E. Zimmerman*
(Residence in Baltimore: No. *3407 Harwood Centre, Canton*) St. *25* yrs. *11* mos. *23* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*
4-COLOR OR RACE *White*
5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *married*
6-DATE OF BIRTH *June 12, 1888*
7-AGE *25* yrs. *11* mos. *23* ds. or *1* day, *11* hrs., *23* min.?
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) *Housewife*
9-BIRTHPLACE (State or country) *Md.*

PARENTS

10-NAME OF FATHER *Patrick Cronin*
11-BIRTHPLACE OF FATHER (State or country) *Ireland*
12-MAIDEN NAME OF MOTHER *Patricia Downing*
13-BIRTHPLACE OF MOTHER (State or country) *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. B. Curry*
(Address) *J. H. Hoob*

JUN 7 - 1915

ROBERT KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 5, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *May 6, 1915*, to *June 5, 1915*, that I saw her alive on *June 5, 1915*, and that death occurred, on the date stated above, at *5:35 p.m.*
The CAUSE OF DEATH* was as follows:

Pneumococcus
Septicaemia

Contributory (SECONDARY) *lobar pneumonia* (Duration) yrs. mos. ds.

(Signed) *E. D. Glass* (Duration) yrs. mos. ds. *June 5, 1915* [Address] *J. H. Hoob* M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. *30* In the State *25* yrs. *11* mos. *23* ds.
Where was disease contracted, if not at place of death?
Former or usual residence *3407 Harwood Centre*

19-PLACE OF BURIAL OR REMOVAL *Mount Carmel*

DATE OF BURIAL *June 8, 1915*

20-UNDERTAKER *Girkler Girkler*

ADDRESS *1739 E. Eager*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85879

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N. Front ST.; 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME

(Residence in Baltimore: No. 225 N. Front St. St.; 25 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <u>Female</u>	4-COLOR OR RACE, <u>white</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <u>Widowed</u>
6-DATE OF BIRTH, <u>June</u> <u>12</u> <u>1844</u> (Month) (Day) (Year)		
7-AGE, <u>71</u> yrs. <u>—</u> mos. <u>—</u> ds.		8-LESS than 1 day, ...hrs. or...min.?
9-OCCUPATION: (a) Trade, profession, or particular kind of work... <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer).....		

PARENTS.	10-NAME OF FATHER, <u>Unknown</u>
	11-BIRTHPLACE OF FATHER (State or Country), <u>Russia</u>
	12-MAIDEN NAME OF MOTHER <u>Unknown</u>
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Russia</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis(Address) 1419 E. Balt. St.

15-

JUN 7 1915

ROBERT F. KRAUTER,

Filed, 191. 1419 E. Balt. St.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,
June 7 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 1915, to June 7 1915, that I saw her alive on June 7 1915, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was, as follows:

Asphyxia
due to fractured skeleton
(Duration).....yrs.....mos. 4 hrs.CONTRIBUTORY
(Secondary)(Signed) M. Childers M. D.
June 7 1915 (Address) 216 N. High St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos. 4 hrs. In the State.....yrs.....mos. 4 hrs.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Int. Burial Co. 6/7/1915

20-UNDERTAKER

ADDRESS

Jack Lewis 1419 E. Balt. St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85880

C85880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *210 East Cross* ST. *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *210 East Cross* St. *38* yrs. *5* mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH

December 31, 1876
(Month) (Day) (Year)

7-AGE.

38 yrs. *5* mos. *4* ds.If LESS than 1 day.
...hrs. or ...min.f

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Ship Joiner*
Ship Yard

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER

Charles A. Potter

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Catherine Hulman

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUN 7 - 1915

ROBERT J. KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 5th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *December 1914* to *June 5 1915*, that I saw him alive on *June 5 1915*, and that death occurred, on the date stated above, at *5:50 P. m.* The CAUSE OF DEATH* was as follows:
Exhaustion

CONTRIBUTORY (Secondary)

Diabetes Mellitus
(Signed) *G. P. Buxton* M. D.
June 5, 1915 (Address) *301 East Cross St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Edgar Hill Cemetery *June 8, 1915*

20-UNDERTAKER

ADDRESS.

W. J. Thompson *1018 E. Light St.*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Johns Hopkins Hosp.* ST. *7* WARD)

FULL NAME

(Residence in Baltimore: No. *14 Ashland Ave. Orangeville* St. yrs. mo. da.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Child

6-DATE OF BIRTH,

Aug 26th, 1912
(Month) (Day) (Year)

7-AGE,

2 yrs. *10* mos. *12* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Child*9-BIRTHPLACE,
(State or Country),*md*

10-NAME OF FATHER,

*Gershon Caplan*11-BIRTHPLACE OF FATHER
(State or Country),*Russia*

12-MAIDEN NAME OF MOTHER

*Lena Kohen*13-BIRTHPLACE OF MOTHER
(State or Country),*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 7th, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest*
(Inquest, au-topsy or inquiry.) And that said deceased came to *his* death
on the day stated above.

The CAUSE OF DEATH* was as follows:

(Accident) Fractured skull from
gun shot wound caused by father
Gershon Caplan (Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Elyah Kiesel* M. D.(Coroner.) *June 7, 1915* (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Hebrew Herring Run**June 7, 1915*

20-UNDERTAKER

ADDRESS *1107 E**J. Simpson & Bro**Balto*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85882

REGISTERED NO. C

126 C85882

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

Sr.; 72 yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

6-DATE OF BIRTH July 26, 1842

7-AGE 72 yrs. 10 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Tobacco laser

9-BIRTHPLACE (State or country) Germany

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 JUN 7 - 1915

Filed

191

HARRY O. ANDREWS

Baptist Parsonage

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 5, 1915

17- I HEREBY CERTIFY, That I attended deceased from May 12, 1915 to June 5, 1915 that I saw him alive on June 4, 1915 and that death occurred, on the date stated above, at 2 a m. The CAUSE OF DEATH* was as follows:

Hypertrophy of prostate
Glaucous, cardiac
failure
(Duration) yrs. mos. 22 ds

Contributory (SECONDARY)

Senility

(Signed)

June 4, 1915 (Address) 1508 Mt. Royal Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Louden Park Cem

20-UNDERTAKER

Mrs J. E. Evans & Son 1418 S. 6th

DATE OF BURIAL

June 5, 1915

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85983

C85983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.; *14* WARD)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. mos. *26* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *single* (Write the word.)

6-DATE OF BIRTH, *April 12th, 1915*
(Month) (Day) (Year)

7-AGE, *1* yrs., *1* mos., *26* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.
10-NAME OF FATHER, *Unknown*
11-BIRTHPLACE OF FATHER (State or Country), *Unknown*
12-MAIDEN NAME OF MOTHER, *Unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15- *JUN 7 - 1915* HARRY O. ARLECK, Registrar.
Filed *191* Burial Permit Olor's

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 7th, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 1st 1915* to *June 6th 1915*, that I saw him alive on *June 6th 1915*, and that death occurred, on the date stated above, at *2:15* p. m. The CAUSE OF DEATH* was as follows:

Malnutrition & Malassimilation
(Duration) *1* yrs., *1* mos., *26* ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs., *1* mos., *26* ds.
(Signed) *Charles G. Hall* M. D.
June 7th, 1915 (Address) *1612 E. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *26* ds. In the State yrs. *1* mos. *26* ds.

Where was disease contracted, if not at place of death? *St. Vincent's Infant Asylum*

Former or usual residence *St. Vincent's Infant Asylum*

19-PLACE OF BURIAL OR REMOVAL, *Cathedral* DATE OF BURIAL, *June 7th, 1915*

20-UNDERTAKER *W. Fahy* ADDRESS *606 Lafayette St.*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85884

C85884

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.; *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. mos. *21* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)

6-DATE OF BIRTH, *May 16th*, 1915
(Month) (Day) (Year)

7-AGE, *21* yrs. mos. *21* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15- *JUN 7 1915* HARRY O. ARKES, Registrar.
Filed..... 191... Serial Permit. Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 6th*, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 16th* 1915, to *June 5th* 1915, that I saw him alive on *June 5th* 1915, and that death occurred, on the date stated above, at *8:00 a.m.* The CAUSE OF DEATH* was as follows:

Congenital syphilis
(Duration)..... yrs. mos. *21* ds.

CONTRIBUTORY (Secondary).....

(Duration)..... yrs. mos. ds.
(Signed) *Elmer G. Hall* M. D.
June 7, 1915 (Address) *1617 E. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *21* ds. In the State yrs. mos. *21* ds.

Where was disease contracted, if not at place of death? *St. Vincent's Infant Asylum*
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cathedral *June 7, 1915*
20-UNDERTAKER, ADDRESS *M. Fahney, Sonnet, Fayette*

State of Maryland, to wit: Baltimore, ss. I, the undersigned, being a duly qualified Registrar of Deaths for the City and County of Baltimore, do hereby certify that the foregoing is a true and correct copy of the original of the Certificate of Death of the person named therein, as the same appears from the records of the Health Department of the City of Baltimore, and that the same has been filed in the office of the Registrar of Deaths for the City and County of Baltimore, and that the same is a true and correct copy of the original of the Certificate of Death of the person named therein, as the same appears from the records of the Health Department of the City of Baltimore, and that the same has been filed in the office of the Registrar of Deaths for the City and County of Baltimore.

C85885

HEALTH DEPARTMENT—CITY OF BALTIMORE

x 104 C85885

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hospital* ST. *7*)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *3407 Hammond Centre* St.; yrs. mos. ds.)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

May 8, 1915
(Month) (Day) (Year)

7-AGE,

— yrs. — mos. 26 ds.

If LESS than 1 day,

— hrs. or — min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Md.*

PARENTS.

10-NAME OF FATHER,

William Zimmerman

11-BIRTHPLACE OF FATHER

(State or Country), *Md.*

12-MAIDEN NAME OF MOTHER

Marie Cohen

13-BIRTHPLACE OF MOTHER

(State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

JUN 7 - 1915

191

HARRY O. JOHNSON

Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 8, 1915, to June 3, 1915.*that I saw him alive on *June 3, 1915.*and that death occurred, on the date stated above, at *3 a.m.*

The CAUSE OF DEATH* was as follows:

gastro-enteritis(Duration) — yrs. — mos. *14* ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. *14* ds.(Signed) *Ed. Plass* M. D.*June 4, 1915* (Address) *J. H. Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

HOSPITAL

PLACE OF BURIAL,

JUN 7 - 1915

ADDRESS

FOR ANATOMICAL PURPOSES.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85886

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1844 E. Chase* ST.; *8* WARD)

REGISTERED NO. C

2-FULL NAME

Vincent Silvestri

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1844 E. Chase St.* St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Married

6-DATE OF BIRTH,

October 28, 1835
(Month) (Day) (Year)

7-AGE,

79 yrs. *7* mos. *8* ds.IF LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business,
or establishment in which
employed (or employer).*Retired
Fruit Dealer*9-BIRTHPLACE,
(State or Country),*Italy.*10-NAME OF
FATHER,*Nicola Silvestri*11-BIRTHPLACE
OF FATHER
(State or Country),*Italy*12-MAIDEN NAME
OF MOTHER*Giuseppa Baldanza*13-BIRTHPLACE
OF MOTHER
(State or Country),*Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Nicola Silvestri*(Address) *1844 E. Chase St.*

15-

Filed

*JUN 7 - 1915**HARRY O. ANDREWS,**191...Burial Permits Officer*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 6th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I saw h alive on *May 28th, 1915*and that death occurred, on the date stated above, at *6:15* m.

The CAUSE OF DEATH* was as follows:

(Duration)....yrs....mos....ds.

CONTRIBUTORY
(Secondary)

(Duration)....yrs....mos....ds.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. Is the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Am.

DATE OF BURIAL,

June 8th, 1915

20-UNDERTAKER

Fully & Fisher

ADDRESS

4038 Maple St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85887

CERTIFICATE OF DEATH.

81 C85887

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 S Duncan ST.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Hanna M. Mestel(Residence in Baltimore: No. 112 S Duncan St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widowed
(Write the word.)6-DATE OF BIRTH. Sept 1, 1838
(Month) (Day) (Year)7-AGE. 76 yrs., 9 mos., 5 ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country). Germany10-NAME OF FATHER. Don't know11-BIRTHPLACE OF FATHER (State or Country). Germany12-MAIDEN NAME OF MOTHER. Don't know13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Mollie Mestel(Address). 112 S Duncan15- JUN 7 - 1915 HARRY D. ANDERSON
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 5, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 5/10 1915, to 6/5 1915, that I saw her alive on 6/5 1915, and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis (Renal)
(Cardiac Asthenia)
(Duration). Don't know ds.CONTRIBUTORY (Secondary). No contribs(Duration). 10 yrs., mos., ds.
(Signed). J. F. France M. D.
6/7, 1915. (Address). 2939 N. Eberly

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs., mos., ds. In the State. yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St. Alphonsus DATE OF BURIAL. June 5, 191520-UNDERTAKER. Wendell Rapp ADDRESS. 37 S M

important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 229 S. Wolfe ST. WARD)

2-FULL NAME Mary Staszewska

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 229 S. Wolfe St. 18 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

June

(Day)

1869

(Year)

7-AGE

46

yrs.

mos.

ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

Housewife

9-BIRTHPLACE

(State or country)

Poland

10-NAME OF
FATHER

Not Known

11-BIRTHPLACE
OF FATHER
(State or country)

Poland

12-MAIDEN NAME
OF MOTHER

Not Known

13-BIRTHPLACE
OF MOTHER
(State or country)

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Staszewski

(Address) 229 S. Wolfe St.

15-

JUN 7 - 1915

191

HARRY O. ANDERSON,
Bureau Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

6

1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 1, 1915, to, June 6, 1915,

that I saw him alive on June 6, 1915,

and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

acute Bronchitis

(Duration)

yrs.

mos.

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

J. J. Staszewski

M. D.

[Address] 18 S. Bond

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place
of death

yrs.

mos.

in the
dc. State

yrs.

mos.

ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary

DATE OF BURIAL

June 8, 1915

20-UNDERTAKER

Jacob Esilkowski

ADDRESS

429 S. Bond

St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85889

CERTIFICATE OF DEATH

C85889

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 5 WARD) St. 2 yrs. 3 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH March 3, 1913 (Month) (Day) (Year)

7-AGE 2 yrs. 3 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Child

9-BIRTHPLACE (State or country)

Baltimore Md

10-NAME OF FATHER Milton Mc. Kelvey

11-BIRTHPLACE OF FATHER (State or country) Balt Co Md

12-MAIDEN NAME OF MOTHER Anna Brehm

13-BIRTHPLACE OF MOTHER (State or country) Baltimore, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Lily Smith

(Address) 505 Colver St

JUN 7 - 1915

Filed

191

HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 7, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 24, 1915, to June 7, 1915.

that I saw him alive on June 7, 1915.

and that death occurred, on the date stated above, at 6:00 m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Acute Nephritis

(Duration) yrs. mos. ds.

(Signed) J. E. Kelly M. D.

June 7, 1915 (Address) 10 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cockeysville Md, June 8, 1915

20-UNDERTAKER

Address Linton T. Fussell 2620 St Paul

10 a.m.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 N. Franklin St. 19 WARD)

2-FULL NAME Catharine E. Kuierum

(Residence in Baltimore: No. 1808 N. Franklin St. 32 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

6-DATE OF BIRTH May 24 1889 (Month) (Day) (Year)

7-AGE 76 yrs. 12 mos. 12 ds. or min. If LESS than 1 day, hrs., min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Germany

10-NAME OF FATHER Justis Schik

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Eva Schaefer

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Catharine Kuierum

(Address) 1808 N. Franklin St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 5 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25 1915, to June 5 1915, that I saw her alive on June 5 1915, and that death occurred, on the date stated above, at 7:20 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contributory (SECONDARY) Enteric Colitis (Duration) yrs. mos. ds. 1

(Signed) Henry C. Uhler M.D. June 5 1915 [Address] 1203 N. Fayette St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Cemetery

June 8 1915

20-UNDERTAKER

ADDRESS

Jos. J. Anderson Son 217 S. Penn.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 7 - 1915.

HARRY O. ANDREWS,
Burial Permit Clerk
REGISTRAR

PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION. AGE should be stated EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION. N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION. state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

HEALTH DEPARTMENT-CITY OF BALTIMORE
CERTIFICATE OF DEATH

C85891

C85891

120
3

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No.
2-FULL NAME
Residence in Baltimore: No.

824 E. Pratt
Mary S. Yacca
824 E. Pratt

ST: 3 WARD
St.: 4 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female
4-COLOR OR RACE white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED married
6-DATE OF BIRTH April 11, 1870
7-AGE 45 yrs. 2 mos. ds. or less than 1 day, hrs. min.?
8-OCCUPATION Housework
9-BIRTHPLACE Romania
10-NAME OF FATHER Unknown
11-BIRTHPLACE OF FATHER Romania
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER Romania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Lewis
(Address) 1419 E. Balt St

15. JUN 7 - 1915
HARRY O. ADAMS, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 6, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-6, 1915, to 6-6, 1915, that I saw her alive on 6-6, 1915, and that death occurred, on the date stated above, at 1 P. m. The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Contributory (Duration) 7 yrs. mos. ds. Uraemic Coma
(Signed) Solomon C. Katzoff M. D.
6-6, 1915 (Address) 116 N. Fair St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Woodlawn Cem
20-UNDERTAKER Jack Lewis
DATE OF BURIAL 6/8, 1915
ADDRESS 1419 E. Balt St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *516. N. Stockton* ST. *18* WARD)FULL NAME *William N. Straighten*(Residence in Baltimore: No. *516. N. Stockton* St.: *—* yrs., *—* mos., *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Unknown, *1866*
(Month) (Day) (Year)

7-AGE,

49
yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Day Laborer*9-BIRTHPLACE,
(State or Country),*Cabot Co Md*

10-NAME OF FATHER,

*John Straighten*11-BIRTHPLACE OF FATHER
(State or Country),*Cabot Co Md*

12-MAIDEN NAME OF MOTHER

*Henrietta John*13-BIRTHPLACE OF MOTHER
(State or Country),*Cabot Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Henrietta Straighten
516 Stockton St

15-

FILE

JUN 7 - 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 6th, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 30th *1915*, to *June 6th* *1915*,
that I saw him alive on *June 6th* *1915*and that death occurred, on the date stated above, at *6:30* m.

The CAUSE OF DEATH* was as follows:

Total Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Stachurski M. D.*6/7/15*, *1915* (Address) *117 N. Calverton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Chesapeake Bay

DATE OF BURIAL,

June 8th, *1915*

20-UNDERTAKER

Willie Brown

ADDRESS

306 W. Mount St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

834 China

ST.: 23

WARD)

REGISTERED NO. C

2-FULL NAME

Ophelia May Cook.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

834 China

St.:

yrs.,

mos.

23 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH

May 23, 1915

(Month)

(Day)

(Year)

7-AGE,

yrs. 23 mos. da.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

John T. Cook

11-BIRTHPLACE OF FATHER

(State or Country).

Calvert Co. Md

12-MAIDEN NAME OF MOTHER

Mabel Wallace

13-BIRTHPLACE OF MOTHER

(State or Country).

Balt.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Mr. John G. Cook

(Address).

834 China St

15-

JUN 8 - 1915.

Filed.

191

MORT KRAUTER

MORTAL PERMIT

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

(Month)

7

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 23 1915, to June 7 1915,

that I saw her alive on June 6 1915,

and that death occurred, on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) yrs. mos. 14 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) J. Guy Bowler, M.D.

191... (Address) 136 W. Hill St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn Cem. June 8, 1915.

20-UNDERTAKER

ADDRESS

Geo H. Hodges 609 W. Hill St.

Cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *1126 China* ST.; *23* WARD)FULL NAME *Mildred Taylor*Residence in Baltimore: No. *1126 China St.* St.; yrs. mos. *2* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *female*4-COLOR OR RACE. *Black*5-SINGLE, *infant*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH. *June 2*, 1915
(Month) (Day) (Year)7-AGE. yrs. mos. *2* ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country). *Maryland. Baltimore*10-NAME OF FATHER. *George Gray*11-BIRTHPLACE OF FATHER
(State or Country). *Maryland*12-MAIDEN NAME OF MOTHER. *Lena Taylor*13-BIRTHPLACE OF MOTHER
(State or Country). *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lena Taylor*(Address) *1126 China St.*

15-

JUN 8 - 1915

Filed..... 191.....

ROBERT KRAUTER

MAYOR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *June 4*, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 2* 1915, to *June 4* 1915,that I saw her alive on *June 3* 1915, and that death occurred, on the date stated above, at *4* p.m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *Edward P. Smith* M. D.*June 5*, 1915 (Address) *Mercy St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? *1126 China St.*Former or usual residence *1126 China St.*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mt Auburn *June 8*, 1915.

20-UNDERTAKER

ADDRESS

J. H. Brown & Son *108 N. Main St.*

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85895

x 108

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *108* WARD)

2-FULL NAME

Charles M Jones(Residence in Baltimore: No. *Owens Mills Md.* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

8.26
(Year)

7-AGE,

39

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Teacher

9-BIRTHPLACE,

(State or Country), *Maryland*

10-NAME OF FATHER,

Washington Jones

11-BIRTHPLACE OF FATHER

(State or Country), *Md*

12-MAIDEN NAME OF MOTHER

Mary Gist

13-BIRTHPLACE OF MOTHER

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Jones*(Address) *Owens Mills Md*

15-

JUN 8 1915

Filed

191

June 8/15

ROBERT KRAUTER

MAY 12 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*June**8**1915*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *June 3* 1915, to *June 8* 1915,that I saw him alive on *June 7 (11 P.M.)* 1915,and that death occurred, on the date stated above, at *12-504* m.

The CAUSE OF DEATH* was as follows:

Toxemia following peritonitis

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Appendicitis

(Duration)

yrs.

mos.

ds.

(Signed) *R. L. Johnson* M. D.*June 8, 1915.* (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Owens Mills Md.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Graves Chapel June 10 1915

20-UNDERTAKER

ADDRESS

J. H. Ewing Restoration Md

important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

2-FULL NAME

(Residence in Baltimore: No.)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.,
..... yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from June 3, 1915 to June 7, 1915

That I saw her alive on June 7, 1915, and that death occurred, on the date stated above, at 12 PM.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(Duration)

Contributory
(SECONDARY)

(Duration)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

15-

JUN 8 - 1915

DEPT. KRAUTER

MAYOR PERMIT CLERK

REGISTRAR

16-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

CITY OF BALTIMORE: (No. 2549 20 North ave St. 15 WARD)

2-FULL NAME Emma V. Kolb

(Residence in Baltimore: No. 2549 20 North av St.; 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE white 5-SINGLE married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH 9 27, 1851
(Month) (Day) (Year)

7-AGE 63 yrs. 9 mos. 11 ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore Md

10-NAME OF FATHER Wm J. James

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Seaver

13-BIRTHPLACE OF MOTHER (State or country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida Kolb

(Address) 2549 20 North av

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 6 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-22, 1913, to, 6-7, 1915.

that I saw her alive on 6-7, 1915, and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) several yrs. mos. ds.

Contributory (SECONDARY) Pulmonary

(Duration) 2 yrs. mos. ds.

(Signed), W. H. Seaver M. D.

[Address] 2757 W North av

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Western Ave DATE OF BURIAL June 10, 1915

20-UNDERTAKER W. H. Seaver ADDRESS 2757 W North av

ROBERT KRAUTER

REGISTRAR

JUN 8 - 1915

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 C85893
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1316. Edmondson Ave. St. 16 WARD)

2-FULL NAME

Elizabeth Ward Snyder

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. 1316 Edmondson Ave. St. yrs. 2 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

March 22nd, 1915
(Month) (Day) (Year)

7-AGE

2 yrs. 2 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or country)

Balto Md

10-NAME OF FATHER

Harry Snyder

11-BIRTHPLACE OF FATHER

(State or country)

Newark N. J.

12-MAIDEN NAME OF MOTHER

Edith Salisbury

13-BIRTHPLACE OF MOTHER

(State or country)

St Louis

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Snyder

(Address) 1316 Edmondson Ave

15 JUN 8 - 1915 ROBERT J. BRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 6, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 24, 1915, to June 6, 1915, that I saw him alive on June 6, 1915, and that death occurred, on the date stated above, at 1206 a.m. The CAUSE OF DEATH* was as follows:

Tuber pneumonia at exhaustion

(Duration) yrs. mos. 12 ds

Contributory (SECONDARY)

(Duration) yrs. mos. 24 hrs

(Signed) J. T. O'Sullivan M. D.
June 6, 1915 (Address) 1092 E. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Linden Park

DATE OF BURIAL

6-8, 1915

20-UNDERTAKER

Henry Branning, Son Schneider St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85899 HEALTH DEPARTMENT--CITY OF BALTIMORE 154 C85899

CERTIFICATE OF DEATH

PLACE OF DEATH
CITY OF BALTIMORE (No. 746, W. Lexington St. 4 WARD)
2-FULL NAME Margaret Weigel
(Residence in Baltimore: No. 746 W. Lexington St. 65 yrs. - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS	
3-SEX Female	4-COLOR OR RACE White
5-STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (Write the word) widow	
6-DATE OF BIRTH October 22, 1826 (Month) (Day) (Year)	
7-AGE 88 yrs. 7 mos. 16 ds. If LESS than 1 day, hrs. or min.?	
8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None	
9-BIRTHPLACE (State or country) Germany	
PARENTS	10-NAME OF FATHER William Black
	11-BIRTHPLACE OF FATHER (State or country) Germany
	12-MAIDEN NAME OF MOTHER Unknown
	13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

JUN 8 - 1915

Filed

191

ROBERT KRAUTER,
Baptist Church
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
June 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
Jan 1910, to, June 7, 1915.
that I saw her alive on June 7, 1915.
and that death occurred, on the date stated above, at 12:30 p.m.
The CAUSE OF DEATH* was as follows:

Infirmities of age
(Duration) 3 yrs. 7 mos. 16 ds.
Contributory (SECONDARY) Cardiac asthma
(Duration) 3 yrs. 7 mos. 16 ds.
(Signed) Geo. W. Hemminger, M. D.
June 7, 1915 (Address) 800 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Baltimore Cemetery June 9, 1915

20-UNDERTAKER ADDRESS

Mrs. A. Rohde 730 Fulton

important. See instructions on back of certificate.

Exact statement of OCCUPATION is very

Spec. - 0-2-14 - M. & T. - 2000 Eds.

C85000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

39 C85000

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3835 Clifton Ave. ST. 15)

2-FULL NAME

(Residence in Baltimore: No. 3835 Clifton Ave.)

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 75 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-STATUS.

Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Unknown; 1840
(Month) (Day) (Year)

7-AGE.

75 yrs. — mos. — ds.

If LESS than 1 day.
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Banker

9-BIRTHPLACE. (State or Country).

Balto Ind.

10-NAME OF FATHER.

J. Henry Winkelmann

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Hennetta Brugel

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mollie P. Winkelmann
(Address) 3835 Clifton Ave.

15-

JUN 8 1915
ROBERT BRATTON
Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 6th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 4 1914, to June 6 1915, that I saw him alive on June 6 1915, and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia
(State the disease causing death, or, in deaths from violent causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.)
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Carcinoma of mouth
(Duration) ... yrs. ... mos. ... ds.
(Signed) M. D.
June, 1915. (Address) 108 N. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.

Loudon Park Cemetery

DATE OF BURIAL.

JUN 8 1915

20-UNDERTAKER

Geo. A. Gerbig Balto & Pupa
Sto

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 2528 Penna Ave

ST. 13 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME James Spencer Clark

(Residence in Baltimore: No. 2528 Penna Ave.

St. 13 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH April 26, 1912 (Month) (Day) (Year)

7-AGE 3 yrs. 1 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) City

10-NAME OF FATHER Spencer Clark

11-BIRTHPLACE OF FATHER N. Y. (State or country)

12-MAIDEN NAME OF MOTHER Martha Offutt

13-BIRTHPLACE OF MOTHER City (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Spencer Clark

(Address) 2528 Penna Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 7, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2, 1915, to June 7, 1915, that I saw him alive on June 7, 1915, and that death occurred, on the date stated above, at 11:30 a.m. The CAUSE OF DEATH* was as follows:

Acute Meningitis

(Duration) yrs. mos. 4 ds

Contributory (SECONDARY) Gastric intestinal infection

(Duration) yrs. mos. 5 ds

(Signed) M. B. Burn and Hood M. D.

June 8, 1915 (Address) 626 N. Gilman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park

DATE OF BURIAL June 9, 1915

20-UNDERTAKER

Wm. J. Lickner

ADDRESS North, Va

JUN 8 - 1915

Filed 191

ROBERT KRAUER

MARIAL FORMIC OLE

REGISTRAR

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C85902

CERTIFICATE OF DEATH

151

C85902

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH June 7, 1915 (Month) (Day) (Year)

7-AGE yrs. mos. ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE (State or country) Maryland

10-NAME OF FATHER Henry Henry Owens

11-BIRTHPLACE OF FATHER (State or country) Maryland

12-MAIDEN NAME OF MOTHER Adelaide K. Bond

13-BIRTHPLACE OF MOTHER (State or country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adelaide H. Owens

(Address) 916 North Carrollton Ave.

15-JUN 8 - 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 7, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from June 7, 1915, to June 7, 1915, that I saw him alive on June 7, 1915, and that death occurred, on the date stated above, at 9 p. m. The CAUSE OF DEATH* was as follows:

Unknown - Premature birth - 6 months -

(Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) H. M. Watson M. D. June 8, 1915 (Address) 102 North Lafayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Cem June 8, 1915

20-UNDERTAKER

Wm. J. Jackson York & Perry

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85903

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Union Protestant Infirmary*
 CITY OF BALTIMORE: (No. *1514* Division ST.; *20* WARD)

REGISTERED NO. C

2-FULL NAME *John M.P. Houck*
 (Residence in Baltimore: No. *2009 W. Saratoga* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married*
 (Write the word.)

6-DATE OF BIRTH, *February 1, 1870*
 (Month) (Day) (Year)

7-AGE, *45* yrs. *4* mos. *5* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, *Clerk*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore, Md.*

10-NAME OF FATHER, *Dr. Jacob W. Houck*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER *Susan Porter*

13-BIRTHPLACE OF MOTHER (State or Country), *Maryland.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Holloway*
 (Address) *Roland Ave. N. York*

15-JUN 8-1915
 Filed

REGISTRAR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 6, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 24 1915*, to *June 6 1915*, that I saw him alive on *June 6 1915*, and that death occurred, on the date stated above, at *6:30 P.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of esophagus
(operation)
May 25, 1915
 (Duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary) *myocarditis*

(Duration) *15* yrs. mos. ds.
 (Signed) *R. F. Kieffer* M. D.
, 191... (Address) *N. York*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *14* yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *Baltimore*

Former or usual residence *2009 W. Saratoga St.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *June 7, 1915*

UNDERTAKER *St. Olivot Cemetery*

ADDRESS *Stewart-Morven Co 108 W. North Ave.*

See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

In taxicab in front of

CITY OF BALTIMORE (No.

2040 Rutaw Place,

ST.

WARD)

REGISTERED NO. C

FULL NAME

John E. Schwarts,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No.

3719 Reisterstown Road.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male,

4-COLOR OR RACE,

White,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married,

6-DATE OF BIRTH,

August 24th, 1868.

7-AGE,

46

8

15

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Accountant in Railroad office.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country),

Pennsylvania,

10-NAME OF FATHER,

Samuel Schwarts,

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown,

12-MAIDEN NAME OF MOTHER

Unknown,

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Frank H. Schwarts, son,

(Address). 3719 Reisterstown Road.

15-

JUN 8 - 1915

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 7th, 1915.

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

thereon and from the evidence obtained by said inquiry

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation,

CONTRIBUTORY

(Signed)

(Duration) yrs. mos. ds.

June 7, 1915. (Address) 3310 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Blairsville Indiana Co. Pa.

June 9, 1915

20-UNDERTAKER

ADDRESS

Stewart Thowen Co., 108 W. North Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *103*)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *Baltimore and Payson*)St.: *2* yrs., *7* mos. *20* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH,

April 1st 1830
(Month) (Day) (Year)

7-AGE

85 yrs., *2* mos., *6* ds.

If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE, (State or Country).

Germany

PARENTS.

10-NAME OF FATHER,

Mr. Brown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Mr. Brown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert J. Krauter
Fwd. JUN 8- 1915, 1711 Permit Office
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 7, 1915*that I saw him alive on *June 1, 1915*,and that death occurred, on the date stated above, at *4:30 p. m.*

The CAUSE OF DEATH* was as follows:

Acute La Grippe(Duration) ...yrs. ...mos. *10 hours*

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) *F. W. Hobelmann* M. D.*June 7, 1915* (Address) *1908 N. Balto. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs. *2* mos. *20* ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Ave.

DATE OF BURIAL,

June 9, 1915

20-UNDERTAKER

Joseph Brooks

ADDRESS

1003 N. Balto St.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85906

CERTIFICATE OF DEATH.

151 C85906

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N. Preston ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 509 N. Preston St.; yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 28, 1915 (Month) (Day) (Year)

7-AGE, yrs. mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ind. Balto

10-NAME OF FATHER, Washington Kress

11-BIRTHPLACE OF FATHER, (State or Country), Ind.

12-MAIDEN NAME OF MOTHER, Quora Quinn

13-BIRTHPLACE OF MOTHER, (State or Country), Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Quora Quinn

(Address) 509 N. Preston St.

15- JUN 8 - 1915 ST. MARTIN'S, KRAUTER

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6 7, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 5 1915, to June 7 1915, that I saw him alive on " " 1915, and that death occurred, on the date stated above, at 8:10 m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration)..... yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) General debility

(Duration)..... yrs. mos. 10 ds.

(Signed) J. H. Thompson M. D.

....., 191... (Address) 1019 Dumbell St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the yrs. mos. ds. State.....

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Martin's Church

DATE OF BURIAL, June 8, 1915

20-UNDERTAKER, J. H. Thompson

ADDRESS 1019 Dumbell St.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85907

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85907

CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 540 E 22^d St. 9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11L.)

2-FULL NAME Charles S Haugh

(Residence in Baltimore: No. 540 E 22^d St. 17 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX <u>male</u>	4-COLOR OR RACE <u>white</u>	5-SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH <u>October</u> <u>17</u> <u>1872</u> (Month) (Day) (Year)		
7-AGE <u>42</u> yrs. <u>7</u> mos. <u>20</u> ds. or min.?		
8-OCCUPATION (a) Trade, profession or particular kind of work <u>wealthy fruitman</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>had no occupation</u>		
9-BIRTHPLACE (State or country) <u>Baltimore Md</u>		
PARENTS	10-NAME OF FATHER <u>John Haugh</u>	
	11-BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>	
	12-MAIDEN NAME OF MOTHER <u>Henonah Broder</u>	
	13-BIRTHPLACE OF MOTHER (State or country) <u>Ireland</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Amelia J. Haugh

(Address) 540 E. 22^d St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
June 6 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2, 1915, to June 6, 1915, that I saw him alive on June 6, 1915, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:
General Paralysis

(Duration) 3 yrs. mos. ds.

Contributory (SECONDARY) Paralysis of the Cord

(Duration) yrs. 4 mos. ds.

(Signed) Henry Westbrook M.D.

June 7, 1915 (Address) 1850 French ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 6/9, 1915.

20-UNDERTAKER Henry W. Marshall

ADDRESS 5057, Calver St

JUN 8 - 1915

DEPT. OF HEALTH
CAROL BERTH
REGISTERED

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85908

CERTIFICATE OF DEATH.

79 C85908
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 E Chase St.)

4-FULL NAME

(Residence in Baltimore: No. 1714 E Chase

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 44 yrs., — mos., — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH.

September 1st, 1843

(Month)

(Day)

(Year)

7-AGE,

71 yrs., 9 mos., 6 da.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired

Machinist

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Edward Schulze

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Christina Poetsch

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Marguit Schulze

(Address)

1714 E Chase St.

15-

JUN 8 - 1915

Filed

191

ROBERT KRAUTER

Official Death Certificate

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 7th, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 3rd, 1915, to June 7th, 1915that I saw him alive on June 7th, 1915and that death occurred, on the date stated above, at 12¹⁰ P.M.

The CAUSE OF DEATH* was as follows:

Coronary atherosclerosis

(Duration) — yrs., — mos., 5 da.

CONTRIBUTORY (Secondary)

Senile Debility

(Duration) 3 yrs., — mos., — da.

(Signed)

June 8th, 1915. (Address) 1301 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

London Park Cemetery

DATE OF BURIAL.

June 10, 1915

20-UNDERTAKER

Henry Horch

ADDRESS

1301 E. Eager St.

Specimen of certificate in plain form, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85009

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85009

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *2376* Ward *13*)

FULL NAME

(Residence in Baltimore: No. *2376* Ward *13*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *2* yrs., *1* mos. *1* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

Married

6-DATE OF BIRTH

June 21st, 1850
(Month) (Day) (Year)

7-AGE

63 yrs. *11* mos. *16* da.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housekeeper

9-BIRTHPLACE, (State or Country).

Virginia

10-NAME OF FATHER

Geo. W. Peebles

11-BIRTHPLACE OF FATHER (State or Country).

La

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mark A. Davis
2376 Druid Hill Ave.

JUN 8 - 1915

Filed

191

HARRY O. ANDREWS,

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 7th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

Whereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Bright's disease
intensely chronic interstitial nephritis
(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

Uremic coma
(Duration) ... yrs. ... mos. ... da.

(Signed) *Wm. M. Savage, M.D.* (Coroner)

June 8, 1915 (Address) *1729 Madison St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Charles

DATE OF BURIAL

June 8, 1915

20-UNDERTAKER

Am. M. Co.

ADDRESS

624 Mt. Royal Ave.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 E 20th ST. 12 WARD)

2-FULL NAME Mary E Dallan

(Residence in Baltimore: No. 427 E 20th St. yrs. 8 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED Widow
(Write the word)

6-DATE OF BIRTH June 23 1873
(Month) (Day) (Year)

7-AGE 91 yrs. 11 mos. 16 ds. or If LESS than 1 day, hrs. min.?

8-OCCUPATION (a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) (Housework)

9-BIRTHPLACE (State or country) Baltimore Md

10-NAME OF FATHER John Standiford

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E Dallan

(Address) 427 E 20th St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1st, 1915, to, June 7, 1915, that I saw her alive on June 6, 1915, and that death occurred, on the date stated above, at 12:28 m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(Duration) yrs. don't know mos. ds.

Contributory (SECONDARY) Infirmities of age

(Duration) yrs. don't know mos. ds.

(Signed) R. P. Carman M. D.

June 7, 1915 [Address] 1701 N. Caroline

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Forest Hill Md

DATE OF BURIAL June 8, 1915

20-UNDERTAKER James R. Byrnes

ADDRESS 514 Wilkes

15- JUN 8 - 1915

MARY O. ABLE

Burial Permit Clerk

REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85912

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85912

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

408 S Bethel

Katherine Wiprecht

408 S Bethel St

St.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and SM out No. 18.)

St.; 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Nov

13, 1853

(Month)

(Day)

(Year)

7-AGE

61

7

17

If LESS than

1 day,

hrs.

or

min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE

(State or country)

Germany

10-NAME OF FATHER

Jacob Pozysk

11-BIRTHPLACE OF FATHER

(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Agnes Novakowska

13-BIRTHPLACE OF MOTHER

(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Wiprecht

(Address)

408 S Bethel St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

5

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 15, 1915, to, June 5, 1915,

that I saw her alive on June 3, 1915,

and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows:

Senile Bronchitis

Contributory (SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Rosary

June 9, 1915

20-UNDERTAKER

ADDRESS

Jacob Fialkowski

428 S Bond

18-JUN 8 - 1915

HARRY O. ANDREWS,
Marial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1641 N. Wolfe* ST.: *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Samuel H. Curtain*(Residence in Baltimore: No. *1641 N. Wolfe* St.: *18* yrs., *11* mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE. *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH. *July 14, 1896*

(Month)

(Day)

(Year)

7-AGE. *18* yrs., *11* mos., *—* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Candy Helper*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *James Curtain*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Emma Chesapeake*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Emma Curtain*(Address) *1641 N. Wolfe*

15-

Filed *WIN 8-1915*

191

HARRY O. ANDREWS,

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 7th, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 1914*, to *June 1915*,that I saw him alive on *June 6, 1915*, and that death occurred, on the date stated above, at *2:40 a.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *6* yrs., *6* mos., *—* ds.

CONTRIBUTORY (Secondary).....

(Duration) *—* yrs., *—* mos., *—* ds.(Signed) *J. Walter Thomas* M. D.*June 7, 1915* (Address) *1228 N. S. and W. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs., *—* mos., *—* ds. In the State *—* yrs., *—* mos., *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park*DATE OF BURIAL, *June 7, 1915*20-UNDERTAKER *William Cook*ADDRESS *502 E. 1st St.*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85915

C85915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *215 E Heath*ST.; *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Anna M. Frailey(Residence in Baltimore: No. *215 E Heath St.*St.; *50* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Widow*

6-DATE OF BIRTH,

*Jan 20**1827*

7-AGE,

88 yrs. *4* mos. *17* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Home

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

Michael Reym

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Wm. Egan

13-BIRTHPLACE OF MOTHER (State or Country),

Wm. Egan

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. J. Frailey

(Address)

215 E Heath St.

15-

JUN 8 - 1915

HARRY O. ANDERSON

Filed....., 191..

Burial Permit No. *0101*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 6, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 31, 1915, to June 6, 1915,*that I saw her alive on *June 6, 1915,*and that death occurred, on the date stated above, at *6 P* m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction(Duration) yrs. mos. ds. *7* ds.

CONTRIBUTORY (Secondary)

Exhaustion(Duration) yrs. mos. ds. *2* ds.

(Signed)

*R. B. Campbell**June 7, 1915* (Address) *644 E. Enoch St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Cross Cemetery

DATE OF BURIAL,

June 9, 1915

20-UNDERTAKER

H. M. G. Flynn

ADDRESS

1422 Light

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85916

C85916

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *23 N. Fulton Ave* 19

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *23 N. Fulton Ave* St.:*48* yrs., *11* mos., *16* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

June 22, 1866
(Month) (Day) (Year)

7-AGE,

48 yrs., *11* mos., *16* ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*

9-BIRTHPLACE, (State or Country).

Baltimore Md.

10-NAME OF FATHER,

Michael Bradley

11-BIRTHPLACE OF FATHER (State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alice Bradley*(Address) *23 N. Fulton Ave*

15-

Filed

JUN 8 - 1915

HARRY O. ARTHURS,

1915 Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 6, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*March 4, 1915, to June 6, 1915;*that I saw him alive on *June 6, 1915;*and that death occurred, on the date stated above, at *6 P. m.*

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis(Duration) *1* yrs., *1* mos., *1* ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis(Signed) *J. L. Lumsden* M. D.*June 6, 1915* (Address) *645 Columbia*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery *June 9, 1915*

20-UNDERTAKER

ADDRESS

H. & M. E. Flynn *1422 Light St.*

Check or print in plain text, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C85917

CERTIFICATE OF DEATH

50

C85917

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

1111 Battery Ave

Elizabeth Randol

1111 Battery Ave

REGISTERED No. C

St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and omit No. 13.)

59 yrs. 6 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Nov. 15, 1855

(Month) (Day) (Year)

7-AGE

59 yrs. 6 mos. 21 ds.

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE
(State or country)

Baltimore, Md.

10 NAME OF FATHER

Thomas Besney

PARENTS

11 BIRTHPLACE OF FATHER
(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Bridget Cluney

13 BIRTHPLACE OF MOTHER
(State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Andrew J. Randol

(Address)

1111 Battery Ave

15

Filed

JUN 8 - 1915

HARRY O. ANDREWS,

Marial Permit Officer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 7, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 6, 1915, to June 7, 1915,

that I saw him alive on June 6, 1915,

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Contributory
(SECONDARY)

Coronaries

(Signed)

Wm. H. Chambers, M.D.

June 8, 1915

(Address)

1012 W. Zafra St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence

In the

State

Yrs. Mos. Ds.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

June 10, 1915

20-UNDERTAKER

ADDRESS

F. A. Krause

703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 823 Sarah Ann St. 18 WARD)
FULL NAME Mary Bailey
(Residence in Baltimore: No. 823 Sarah Ann St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX Female	4-COLOR OR RACE Col	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow
6-DATE OF BIRTH Unknown 1 (Month) (Day) (Year)		
7-AGE 52 yrs. mos. ds.		8-LESS than 1 day. hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Housework		
9-BIRTHPLACE, (State or Country). Maryland		
PARENTS.	10-NAME OF FATHER Unknown	
	11-BIRTHPLACE OF FATHER (State or Country). Unknown	
	12-MAIDEN NAME OF MOTHER Hannet Hudson	
	13-BIRTHPLACE OF MOTHER (State or Country). Maryland	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Bailey
(Address) 823 Sarah St.

15- JUN 9 - 1915 ROBERT J. KRAUTER,
Filed. 1915. Official Permit Clerk,
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Edema of Lungs
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chf. Ht. Hypertosis
(Duration) yrs. mos. ds.
(Signed) M. D.
(Coroner.)
, 1915. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,
Catholic Cemetery June 9, 1915.
20-UNDERTAKER ADDRESS
Geo H Hooper 609 South 19th St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85919

C85919

1. PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1338 Argyle ST. 17 WARD)

2. FULL NAME

Thomas H. Briscoe Jr.
1338 Argyle

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

Alond

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word)

Single

6. DATE OF BIRTH

Jan 18, 1904
(Month) (Day) (Year)

7. AGE

11 yrs. 4 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

School boy

9. BIRTHPLACE

(State or country)

Baltimore

10. NAME OF FATHER

Thomas H. Briscoe

11. BIRTHPLACE OF FATHER

(State or country)

MD

12. MAIDEN NAME OF MOTHER

Julia Gough

13. BIRTHPLACE OF MOTHER

(State or country)

MD

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas H. Briscoe

(Address)

1338 Argyle

15. JUN 9 - 1915

Filed

1915

REGISTRAR

10. DATE OF DEATH

June 8, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from

May 25, 1915, to, June 8, 1915

that I saw him alive on June 8, 1915

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. mos. 14 ds

Contributory (SECONDARY)

Pneumonia

(Duration) yrs. mos. 3 ds

(Signed)

John E. Briscoe M. D.
June 8, 1915 (Address) 462 Drexel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Peter's Cemetery

DATE OF BURIAL

June 10, 1915

20. UNDERTAKER

Felix B. Pfeiffer 12 E. Mulberry St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85920

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85920

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 523 Colvin St. 5 WARD)

FULL NAME Francesco Pandolfini

(Residence in Baltimore: No. 523 Colvin St. 1 yr. 1 mos. 1 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and add out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

6-MARRIED

7-WIDOWED

8-DIVORCED

9-Write the word

widow

6-DATE OF BIRTH

Aug 30

1855

7-AGE

59 yrs. 9 mos. 23 ds.

If LESS than 1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE
(State or country)

Italy

10-NAME OF FATHER

Francesco Pandolfini

11-BIRTHPLACE OF FATHER
(State or country)

Italy

12-MAIDEN NAME OF MOTHER

Domenica Vigona

13-BIRTHPLACE OF MOTHER
(State or country)

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Francesco De Luca

(Address)

420 East St.

15-

JUN 9 - 1915

ROBERT A. BRAUER,

11111 Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

June 7th 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1915, to June 7th 1915, that I saw him alive on June 7th 1915, and that death occurred, on the date stated above, at 10:40 P.M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis. Hemiplegia of 3 yrs duration. Dry gangrene of lower extremities (Duration) yrs. 10 mos. 10 ds.

Contributory (SECONDARY)

Cardiac thrombosis.

(Duration) yrs. 4 mos. 4 hrs.

(Signed) S. Demareo M. D.

6-8-1915 [Address] 1604 Linden Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Redeemer

DATE OF BURIAL

June 10 1915

20-UNDERTAKER

Chas F. Wasmus

ADDRESS

217 N. Fulton Ave

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should

C85921

HEALTH DEPARTMENT--CITY OF BALTIMORE

PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *3429 Edmondson Ave.* ST. *20* WARD)

8-FULL NAME *Charles E. Farmer*

Residence in Baltimore: No. *3492 Edmondson Ave.* ST. *20* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN or No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Dec 20 1871

7-AGE

43

5 yrs. *18* mos. *18* ds. or min.?

If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Painter

9-BIRTHPLACE

(State or country)

Balt.

10-NAME OF FATHER

Wm. A. Farmer

11-BIRTHPLACE OF FATHER

(State or country)

Balt.

12-MAIDEN NAME OF MOTHER

Virginia H. Doolan

13-BIRTHPLACE OF MOTHER

(State or country)

Balt.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Loretta C. Farmer

(Address)

3429 Edmondson Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 8th 1915

17- I HEREBY CERTIFY, That I attended deceased from *January 1st*, 1915, to *June 7th*, 1915, that I saw him alive on *June 7th*, 1915, and that death occurred, on the date stated above, at *7:50 am.*

The CAUSE OF DEATH* was as follows:

The immediate cause of death was "Cerebral Hemorrhage" running a slow progressive course and lasting nearly 2 yrs.

Contributory (SECONDARY)

Arteriosclerosis

(Duration) *about 9* yrs.

(Signed) *Leahurst P. Woodward*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

7 yrs. *18* mos. *18* ds. In the State *1* yr. *18* mos. *18* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Green Mount

DATE OF BURIAL

June 11 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E. North Ave.

JUN 9 - 1915

ROBERT C. BRAUTER, REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85922

C85922

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1310 Ashland Ave. ST. 10 WARD)
2-FULL NAME John DeCrot Cunningham
(Residence in Baltimore: No. 1310 Ashland Ave St. Lifeline da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOW, OR DIVORCED, Married (Write the word.)
6-DATE OF BIRTH, ? ? 1?
(Month) (Day) (Year)
7-AGE, abt 76 yrs. - mon. - ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). Very Business

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, Samuel D. Cunningham
11-BIRTHPLACE OF FATHER (State or Country), Baltimore
12-MAIDEN NAME OF MOTHER, Susan DeCrot
13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. J. D. Cunningham
(Address) 1310 Ashland Ave.

15- JUN 9 - 1915 ROBERT J. BRAUTER
Filed June 11, 1915 REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1915 to June 8 1915, that I saw him alive on June 8 1915, and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Bright Disease
(Duration) 4 yrs. 4 mos. 4 ds.

CONTRIBUTORY Exhaustion & Cong.
(Secondary)

(Duration) 4 yrs. 4 mos. 4 ds.

(Signed) J. J. Whitcomb M. D.

June 8, 1915 (Address) 1310 Ashland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs. 4 mos. 4 ds. In the State 4 yrs. 4 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, June 11, 1915

20-UNDERTAKER, Stewart & Howen Co

ADDRESS, 108-20 North

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 E 25thST.: 17 WARD)

REGISTERED NO. C

2-FULL NAME Charles Fifth Hampson(Residence in Baltimore: No. 115 E Twenty Fifth

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE,

single

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

March 18, 1914
(Month) (Day) (Year)

7-AGE,

1 yrs. 2 mos. 20 ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), Maryland10-NAME OF FATHER, Walter M. Hampson11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER Bessie Miller13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward S. Hampson(Address) 2702 S. Paul St.

15-

JUN 9 - 1915

ROBERT KRAUTER

Filed..... 191.....

MAY 11 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 8th, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 1st 1915, to June 8 1915,that I saw him alive on June 8 1915,and that death occurred, on the date stated above, at 8:10 A.M.

The CAUSE OF DEATH* was as follows:

Enlarged Glands in the
Mediastinum due to
some unknown infection.
(Duration) about 1 1/2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 1 1/2 mos. ds.(Signed) Harmon H. Cooper M. D.June 9, 1915. (Address) 2425 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

June 10, 1915.

20-UNDERTAKER

Stewart Mowen Co

ADDRESS

108-20 North Ave.

important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85925 HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 C85925

PLACE OF DEATH

CITY OF BALTIMORE (No. 146 East

FULL NAME William Gillyard

(Residence in Baltimore: No. 146 East St.

ST. 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE Black

5-STATUS MARRIED

married

6-DATE OF BIRTH

Dec

18, 1877

7-AGE

37

yrs. mos. ds.

IF LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9-BIRTHPLACE (State or country)

Winchester Va

10-NAME OF FATHER

James Gillyard

11-BIRTHPLACE OF FATHER (State or country)

Winchester Va

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Winchester Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ratie Gillyard

(Address)

146 East St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

7, 1915

17- I HEREBY CERTIFY, That I attended deceased from

May, 1914, to June 6, 1915.

that I saw him alive on June 6, 1915.

and that death occurred, on the date stated above, at 3:00 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory (SECONDARY)

Heart Failure

(Signed)

A. J. Freedom

6/7

(Address) 918 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Winchester Va

June 10, 1915

20-UNDERTAKER

ADDRESS

W. S. Turner

1442 N. Brady

JUN 9 - 1915

ROBERT . KRAUTER

Health Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

085926

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2501 E. Hoffman* ST.; *8* WARD)

FULL NAME

(Residence in Baltimore: No. *2501 E. Hoffman* St.; *73* yrs., *1* mos. *3* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE

white

5-STATUS

Married
~~MARRIED,~~
~~WIDOWED,~~
~~OR DIVORCED,~~
(Write the word.)

6-DATE OF BIRTH

May 3, 1842
(Month) (Day) (Year)

7-AGE

73 yrs., *1* mos., *3* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),*Harford Co Md*

10-NAME OF FATHER,

*Thos Fredway*11-BIRTHPLACE OF FATHER
(State or Country),*Harford Co*

12-MAIDEN NAME OF MOTHER

*Levinus Duncan*13-BIRTHPLACE OF MOTHER
(State or Country),*7 Balt. Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. D. Fredway*(Address) *1323 N. Madison Ave*

15-

JUN 9 - 1915

ROBERT KRAUTER

Corial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 6, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 11, 1915, to *June 6, 1915*that I saw him alive on *June 6, 1915*,and that death occurred, on the date stated above, at *12 a.m.*

The CAUSE OF DEATH* was as follows:

Angina of right leg

.....

.....

..... (Duration) yrs. mos. *10* ds.CONTRIBUTORY
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *W. D. ...* M. D.*June 7, 1915* (Address) *Harford Co Md*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery July 1, 1915

20-UNDERTAKER

ADDRESS

Robt S. Turner 1422 Brady

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85927

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 C85927
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10411 Schroeder St. 18 WARD)

2-FULL NAME Susan Freeland

(Residence in Baltimore: No. 10411 Schroeder St. 78 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

6-DATE OF BIRTH Unknown 1 (Month) (Day) (Year)

7-AGE 78 yrs. mos. ds. or min. If LESS than 1 day, hrs. min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Baltimore Md

10-NAME OF FATHER Peter Clinton

11-BIRTHPLACE OF FATHER Md (State or country)

12-MAIDEN NAME OF MOTHER Susan

13-BIRTHPLACE OF MOTHER Md (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Scribner

(Address) 10511 Carroll St

15- JUN 9 - 1915 ROBERT A. KRAUTER, Corial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 8, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1915, to June 8, 1915, that I saw him alive on June 7, 1915, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Contributory (SECONDARY)

(Signed) J. M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Not Auburn Entry June 10, 1915

20-UNDERTAKER

Alfred J. Freeland 11411 Schroeder St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

085928

CERTIFICATE OF DEATH

79 085928

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 1123 Parvise St. 16 WARD)

2-FULL NAME William Townsend (Townsend)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RG cert No. 18.)

(Residence in Baltimore: No. 1123 2 Parvise St. 4 yrs. 6 mos. ds.)

St. 4 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

May

13, 1882

7-AGE

33

0 mos. 26 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

Cement

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Washington D.C.

10-NAME OF FATHER

William Townsend

11-BIRTHPLACE OF FATHER

Unknown

12-MAIDEN NAME OF MOTHER

Josephine (Unknown)

13-BIRTHPLACE OF MOTHER

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

1400 Mosher

16-DATE OF DEATH

June

8

1915

17- I HEREBY CERTIFY, That I attended deceased from

May 28, 1915, to June 8, 1915,

that I saw him alive on June 8, 1915,

and that death occurred, on the date stated above, at 6:15 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Acute)

Contributory (SECONDARY)

(Duration) yrs. 1 mos. ds.

(Duration) yrs. 1 mos. ds.

(Signed) Herman Nelson M.D.

June 8, 1915. [Address] 1103 2nd St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Ambrose

June 10, 1915

20-UNDERTAKER

ADDRESS

Sam W. C. C. Co.

1400 Mosher

15- JUN 9 - 1915

ROBERT . KRAUTER

Chief of Bureau

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *8* ST.: *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *William Diggs*(Residence in Baltimore: No. *Shurlock Md.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE. *Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*

(Write the word.)

6-DATE OF BIRTH, *Apr. 15, 1885*

(Month)

(Day)

(Year)

7-AGE, *30* yrs. *1* mos. *21* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Letter*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *Geo Diggs*11-BIRTHPLACE OF FATHER (State or Country), *Va*12-MAIDEN NAME OF MOTHER *Not known*13-BIRTHPLACE OF MOTHER (State or Country), *Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo Diggs*(Address) *Colbert St.*

15-

JUN 9 - 1915

Filed.....

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 5, 1915*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *Apr 30, 1915*, to *June 5, 1915*,that I saw him alive on *June 5, 1915*,and that death occurred, on the date stated above, at *3:50* m.

The CAUSE OF DEATH* was as follows:

Acute Potts Disease(Duration) *Not known*CONTRIBUTORY (Secondary) *Bladder Bone Abscess*(Duration) *about 3*

yrs.

mos.

ds.

(Signed) *Edward P. Smith* M. D.June 5, 1915. (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. *1* mos. *5* ds. In the State *La* yrs. mos. ds.Where was disease contracted, if not at place of death? *Shurlock Md.*Former or usual residence *Shurlock Md.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

HOPKINS HOSPITAL

JUN 8 - 1915

Under Secretary Health.

ADDRESS

Per Wm E. WOODALL

FOR ANATOMICAL PURPOSES

Statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.; WARD)

FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St. yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

9-BIRTHPLACE,

(State or Country),

10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 9 - 1915

Filed

ROBERT . KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 31 1915, to June 6 1915

that I saw her alive on June 4 1915

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

About 4 7

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Maurice Jones M. D.

June 8, 1915 (Address) 423 E. Fort St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Cemetery

June 9, 1915

20-UNDERTAKER

ADDRESS

R. M. Flynn

1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

C85931

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *Nursery & Child Hosp.*)
2-FULL NAME *Roland Cooper*
(Residence in Baltimore: No. *nursery child hosp.*)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

Age: *38* yrs., *3* mos., *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
4-COLOR OR RACE, *White*
5-SINGLE, *Child*
MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, *May 7*, 1915
(Month) (Day) (Year)
7-AGE, *38*
If LESS than 1 day,hrs. or....min.f
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *none*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *unknown*

10-NAME OF FATHER, *unknown*

11-BIRTHPLACE OF FATHER (State or Country), *unknown*

12-MAIDEN NAME OF MOTHER, *unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Nursery & Child Hosp.*

(Address) *Nursery & Child Hosp.*

15-
JUN 9 - 1915
Filed..... 1915
ROBERT KRAUTER,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 8*, 1915.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *May 16* 1915, to *June 8* 1915, that I saw him alive on *June 8* 1915, and that death occurred, on the date stated above, at *1:40* m.

The CAUSE OF DEATH* was as follows:
Severe Malnutrition
(Duration).....yrs. *1*.....mos.ds.

CONTRIBUTORY.....
(Secondary)

(Signed) *Edgar J. McDonald* M. D.
Jan 2 8 1915 (Address) *1616 Lenox Ave. N.Y.C.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *24* mos. *3* In the State *2* yrs.mos.ds.

Where was disease contracted, if not at place of death? *?*

Former or usual residence *?*

19-PLACE OF BURIAL OR REMOVAL, *Roller Park Burial*

DATE OF BURIAL, *June 10, 1915*

20-UNDERTAKER, *George J. Smith*

ADDRESS, *707 E. 12th St.*

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85932

PLACE OF DEATH

CITY OF BALTIMORE (No. 2102 Westwood avenue, ST. 15 WARD)

FULL NAME Susan F. Grove,

(Residence in Baltimore: No. 2102 Westwood avenue, St.; yrs. 7 mos. 21 da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, October 17th, / 1895. (Month) (Day) (Year)

7-AGE, 19 yrs. 7 mos. 21 da. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), Maryland,

10-NAME OF FATHER, Francis D. Grove, 11-BIRTHPLACE OF FATHER (State or Country), Maryland, 12-MAIDEN NAME OF MOTHER, Minnie J. Schatz, 13-BIRTHPLACE OF MOTHER (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Francis D. Grove, father, (Address) 2102 Westwood avenue,

15- JUN 9 - 1915 ROBERT KRAUTER, Filed 1915 Serial 1000 Death

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Poisoning by Carbolic acid, (suicide). (Duration)yrs.mos.da.

CONTRIBUTORY (Secondary) None. (Duration)yrs.mos.da. (Signed) J. Frederick Humpel M. D. (Coroner.) June 8, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death....yrs....mos....da. State....yrs....mos....da. In the

Where was disease contracted, if not at place of death?..... Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, June 11, 1915

20-UNDERTAKER, William Cook ADDRESS 502 E. North

C85933

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85933

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *7* WARD)2-FULL NAME *Allen Swift*(Residence in Baltimore: No. *742 N. 1st St. Elmhurst N.Y.* St. yrs. mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

September 13, 1907
(Month) (Day) (Year)

7-AGE

77 yrs. *8* mos. *27* ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Manufacturer*9-BIRTHPLACE
(State or country)*N.Y.*

10-NAME OF FATHER

*David Swift*11-BIRTHPLACE OF FATHER
(State or country)*N.Y.*

12-MAIDEN NAME OF MOTHER

*Wood*13-BIRTHPLACE OF MOTHER
(State or country)*N.Y.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. Phelps
Johns Hopkins Hosp.

JUN 9 - 1915

HARRY O. ARLOFF
Serial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 9, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I attended deceased from

May 14, 1915 to *June 9, 1915*that I saw him alive on *June 9, 1915*and that death occurred, on the date stated above, at *2:00 a.m.*

The CAUSE OF DEATH* was as follows:

Heart pyogenic infection (local) following
left hip fracture (6/4/15)
acute pulmonary embolism (PE)
*acute myocardial infarction*Contributory
(SECONDARY)*Carcinoma Prostate - Pyelonephritis*
Apert 2

(Signed)

William B. Smith
June 9, 1915 [Address] *Johns Hopkins Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *26* ds. State *✓* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *742 N. 1st St. Elmhurst*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elmhurst N.Y. *June 9, 1915*

20-UNDERTAKER

ADDRESS

Albert E. Fuller 224 N. Broadway

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85934

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85934

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3646 Beech Ave.* ST. *13* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Christopher L. G. Meyls*(Residence in Baltimore: No. *3646 Beech Ave.* St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*16-DATE OF DEATH *June 8, 1915*6-DATE OF BIRTH, *Dec. 19, 1871*

(Month)

(Day)

(Year)

7-AGE, *43* yrs., *5* mos., *20* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Boiler Washer*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Lewis O. Meyls*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Alice A. Houck*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Alice A. Meyls*(Address) *3646 Beech Ave.*

15-

JUN 9 - 1915

HARRY O. ANDREWS,

Filed

191

BRYANT FORD,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from *March 8, 1915*, to *June 7, 1915*, that I saw him alive on *June 7, 1915*, and that death occurred, on the date stated above, at *8:45 A.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *1* yrs., *1* mos., *1* ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs., *1* mos., *1* ds.(Signed) *A. J. Davies* M.D.*6-8, 1915* (Address) *800 W. 33 St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. Mary's Hampden**June 10, 1915*

20-UNDERTAKER

ADDRESS

Horace Burger & Son, 3631 Falls Rd.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

328 W. Camden St.

WARD)

FULL NAME

Harry O. Baker

(Residence in Baltimore: No.

138 South Eborod Ave

St.; yrs., 4 mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

Feb 12, 1875

(Month)

(Day)

(Year)

7-AGE,

40 3 27

Yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Actor

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Manchester N.H.

10-NAME OF FATHER,

Merury Baker

11-BIRTHPLACE OF FATHER

(State or Country),

Massachusetts

12-MAIDEN NAME OF MOTHER

Mary E. Welsh

13-BIRTHPLACE OF MOTHER

(State or Country),

Massachusetts

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. E. Sales Baker

(Address)

138 South Eborod Ave

15-

JUN 9 - 1915

HARRY O. ANDREWS,

F.H.D. 191. Social Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 8, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held as an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

No asphyxiation (Suicide)

CONTRIBUTORY (Secondary)

(Signed) J. E. Andrews M. D.

June 8, 1915 (Address) 138 South Eborod Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oak Lawn

June 10, 1915

20-UNDERTAKER

ADDRESS

William Cook

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85936

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85936

CERTIFICATE OF DEATH

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1540 S Charles ST. 23 WARD)2-FULL NAME Naomi R. Morris

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1540 S Charles St.; - yrs. 4 mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Single

6-DATE OF BIRTH

Jan 22 1915
(Month) (Day) (Year)

7-AGE

4 17 ds.
yrs. mos. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)None9-BIRTHPLACE
(State or country)D.C.

10-NAME OF FATHER

Warren Morris11-BIRTHPLACE OF FATHER
(State or country)Baltimore

12-MAIDEN NAME OF MOTHER

Maybelle Holtz13-BIRTHPLACE OF MOTHER
(State or country)D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Morris

(Address)

1540 S Charles

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 8 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 3, 1915, to June 8, 1915,that I saw her alive on June 7, 1915, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Congenital heart diseaseContributory
(SECONDARY)Acute gastro-enteritis
(Duration) yrs. mos. 10 ds.
(Signed) J. F. Hawkey M. D.
June 9, 1915 [Address] 1618 Highland

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cedar Hill

DATE OF BURIAL

6/10, 1915

20-UNDERTAKER

Robt. J. Burdick & Son

ADDRESS

175 Calhoun

JUN 9 - 1915

HARRY O. ANDREWS,

Baltimore Health Officer

REGISTRAR

Filed....., 191

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85937

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85937

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *912 Fawn*ST.: *3rd* WARD)

REGISTERED NO. C

2-FULL NAME

Salvatore Palmisano

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *912 Fawn*St.: *1* yrs., *3* mos. *ds.*

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

*March**9th**1914*

(Month)

(Day)

(Year)

7-AGE,

1 yrs., *3* mos. *ds.*

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE,

(State or Country).

Baltimore Md.

10-NAME OF FATHER,

Anthony Palmisano

11-BIRTHPLACE OF FATHER

(State or Country).

Italy

12-MAIDEN NAME OF MOTHER

Marguerite Giuffre

13-BIRTHPLACE OF MOTHER

(State or Country).

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Toney Palmisano
912 Fawn St.

15-

JUN 9 - 1915

HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June *9th*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 1st* 1915, to *June 9th* 1915, that I saw him alive on *June 9th* 1915, and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. *4* ds.(Signed) *A. Palmisano* M. D.*June 9th* 1915 (Address) *316 S. Exeter St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Vincent Cemetery *June 10, 1915*

20-UNDERTAKER

ADDRESS *1944**Harry W. Ehlert*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85938

HEALTH DEPARTMENT-CITY OF BALTIMORE

C85938

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *25 S. Duncan St*)FULL NAME *Emma Cooper*(Residence in Baltimore: No. *25 S. Duncan St*)

REGISTERED NO. C

ST. *1st* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

St. *27* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Black* 5 ~~SINGLE~~ MARRIED *Married*
(If ~~WIDOWED~~ OR DIVORCED, write the word)6 DATE OF BIRTH *Not known*, 1 (Month) (Day) (Year)7 AGE *about 63* (This is in *years* judgment) If LESS than 1 day, hrs. or min.?8 OCCUPATION (a) Trade, profession, or particular kind of work *House Wife* (b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) *State of Virginia*10 NAME OF FATHER *Don't know*11 BIRTHPLACE OF FATHER (State or country) *Don't know*12 MAIDEN NAME OF MOTHER *Don't know*13 BIRTHPLACE OF MOTHER (State or country) *Don't know*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Annabelle Cooper*(Address) *25 S. Duncan St*

JUN 9 - 1915

HARRY O. A. REGISTRAR
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *June 8*, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Jan 22*, 1915, to *June 8*, 1915.that I saw her alive on *June 8*, 1915, and that death occurred, on the date stated above, at *11:30* A. M.

The CAUSE OF DEATH* was as follows:

*Chronic Parenchymatous Nephritis
(Gen. Arterio Sclerosis)*Contributory *Accidental pulmonary edema*
(SECONDARY) (Duration) yrs. *3* mos. ds.(Signed) *Ed. France M.D.* (Address) *2439 McElroy*
6/9, 1915 (M. D.)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

W. T. Auburn Cem. *June 10th, 1915*

20 UNDERTAKER

ADDRESS

Harry A. Vodery 1725 Orleans St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85940

C85940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Franklin Sq., Nos. 22

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Mary Sabalouckas

Residence in Baltimore: No.

231 S. Greene

St.: 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

not known, 1895

(Month)

(Day)

(Year)

7-AGE,

20 yrs., mos., ds.

10 LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Tailor

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

Anthony Sabalouckas

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Barbara Horcakis

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anastasia G. Ganchuk

(Address) 215 S. Greene St.

JUN 10 1915

H. KRAUTER,

Filed 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 8, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1915 to June 8, 1915, that I saw her alive on June 8, 1915, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Signed) Geo. H. Evans M. D.
6/8, 1915 (Address) Franklin Sq., Nos. 22

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 231 S. Greene St.

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Cm.

DATE OF BURIAL,

June 11, 1915

20-UNDERTAKER

John Sabalouckas 500 S. Pine St.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85941

45 C85941

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2578 E. Fairmount Ave* WARD) *6*FULL NAME *John Reth*Residence in Baltimore: No. *2578 E. Fairmount Ave* St.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

March 9th, 1852
(Month) (Day) (Year)

7-AGE,

59 yrs. *2* mos. *29* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Sergeant Police*

9-BIRTHPLACE, (State or Country),

Balt. City Md.

10-NAME OF FATHER,

Peter Reth

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Magdalena Schleicher

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Johanna Reth*(Address) *2578 E. Fairmount Ave*

15-

Filed

JUN 10 1915

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 8, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 19, 1911* to *June 7, 1915*, that I saw him alive on *June 7th, 1915*, and that death occurred, on the date stated above, at *2:29* p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Opium Aug 1911 - May 1915
Radium poisoning in 1914 & 1915

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Dr. H. M. Lamm*

M. D.

June 8, 1915 (Address) *2578 E. Fairmount Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Druid Ridge Cem.

DATE OF BURIAL,

June 11, 1915

20-UNDERTAKER

H. Sauer Sons

ADDRESS

1200 Fleet St.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85942

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1628 N. Broadway* ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Benjamin A. Rhodes*(Residence in Baltimore: No. *1628 N. Broadway* St.; *6* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Widowed

6-DATE OF BIRTH,

not known

(Month)

(Day)

(Year)

7-AGE,

*72*yrs. *—* mos. *—* ds.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Retired Driver*9-BIRTHPLACE,
(State or Country),*md.*

10-NAME OF FATHER,

*not known*11-BIRTHPLACE OF FATHER
(State or Country),*not known*

12-MAIDEN NAME OF MOTHER

*not known*13-BIRTHPLACE OF MOTHER
(State or Country),*not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm Albert Seebode

(Address)

1628 N. Broadway

JUN 10 1915

ROBERT KRAUTER,

Filed..... 1915 Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 5, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov. 16, 1914

to

June 5, 1915

(Year)

that I saw him alive on

*" "**1915*and that death occurred, on the date stated above, at *8:30 P. m.*

The CAUSE OF DEATH* was as follows:

(Cerebral - 30 days)(Duration) *30* yrs. *—* mos. *—* ds.CONTRIBUTORY
(Secondary)(Duration) *30* yrs. *—* mos. *—* ds.

(Signed)

*George A. Hartman, M. D.**June 9, 1915*(Address) *1121 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Cemetery

DATE OF BURIAL,

June 11, 1915

20-UNDERTAKER

Henry Horck & Son

ADDRESS

1301 E. Eager St.

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85943

HEALTH DEPARTMENT—CITY OF BALTIMORE

x142 C85943

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital 4* ST.;

WARD)

2-FULL NAME

George W. Gross
Olivers Md.

(Residence in Baltimore: No. _____

REGISTERED NO. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word.)

Married

6-DATE OF BIRTH.

*Unknown**1837*

(Month)

(Day)

(Year)

7-AGE.

76

yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

Farmer

9-BIRTHPLACE.

(State or Country).

Maryland.

PARENTS.

10-NAME OF FATHER.

George Gross

11-BIRTHPLACE OF FATHER

(State or Country).

Md.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Emmie Phelps

(Address).

1345 Stricker st

15-

Filed

*JUN 10 1915**ROBERT . KRAUTER,**Bureau Permit Clerk.*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 8, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 1, 1915, to June 8, 1915*that I saw him alive on *June 8, 1915*and that death occurred, on the date stated above, at *4 4* m.

The CAUSE OF DEATH* was as follows:

*Septic Gangrene**Arterio Sclerosis General**Senility* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Elmer Yeoman M. D.**6/8/15, 1915.* (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Olivers Md.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*Johnson's Island**June 10, 1915*

20-UNDERTAKER

James H. Lunn

ADDRESS

1303 Preston

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85944

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

44

C85944

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1721 Belt St

ST. 24 WARD)

2-FULL NAME

William J. Hamilton

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1721 Belt St

St. yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

6-DATE OF BIRTH April 24, 1863 (Month) (Day) (Year)

7-AGE 52 yrs. 2 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Barber

9-BIRTHPLACE (State or country) Leslie Co. Md.

10-NAME OF FATHER Joseph H. Hamilton

11-BIRTHPLACE OF FATHER (State or country) Leslie Co. Md.

12-MAIDEN NAME OF MOTHER Ann H. Miller

13-BIRTHPLACE OF MOTHER (State or country) Leslie Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo W. Abrams

(Address) 1721 Belt Ave

15. JUN 10 1915 ROBERT J. KRAUTER

Filed 1915 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 9, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10th, 1915, to June 9, 1915, that I saw him alive on June 9, 1915, and that death occurred, on the date stated above, at 8:20 A.M. The CAUSE OF DEATH* was as follows:

Carcinoma of Ear

(Duration) 2 yrs. - mos. - ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Sidney H. Street, M.D. June 9, 1915 (Address) 431 E. Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Leslie Co. Md.

DATE OF BURIAL June 12, 1915

20-UNDERTAKER ADDRESS George H. Little 531 E. Lexington

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85945

CERTIFICATE OF DEATH

79

C85945

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1765 Carroll St. 9 WARD)

2-FULL NAME John Matture

(Residence in Baltimore: No. 1765 Carroll St. yrs. 7 mos. ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

January

(Month)

6

(Day)

1886

(Year)

7-AGE

79

yrs.

5

mos.

2

ds.

or

min?

If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Contractor

9-BIRTHPLACE

(State or country)

Italy

10-NAME OF FATHER

Not known

11-BIRTHPLACE OF FATHER

(State or country)

Italy

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or country)

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Spencer B. Fisher
1769 Carroll St.

15

JUN 10 1915

ROBERT . KRAUTER,

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

June

(Month)

8

(Day)

1915

(Year)

I HEREBY CERTIFY, That I attended deceased from July 1, 1915, to June 8, 1915,

that I saw him alive on June 8, 1915,

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Heart disease and old age

(Duration) yrs. 4 mos. ds.

Contributory (SECONDARY) Exhaustion

(Duration) yrs. 16 mos. ds.

(Signed) Henry H. Whitlock M. D.

July 8, 1915 (Address) 1618 Broadway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

17-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

18-UNDEBTAKER

ADDRESS

19-ADDRESS

20-ADDRESS

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85946

28 C85946
REGISTERED No. C.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *773 Sarah Ann St.* WARD *4*)

2 FULL NAME

Alex White(Residence in Baltimore: No. *773 Sarah Ann St.* *41* yrs. *4* mos. *18* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*Married*

6 DATE OF BIRTH

July 6, 1873
(Month) (Day) (Year)

7 AGE

*41*If LESS than
1 day, hrs.,
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Labrow*9 BIRTHPLACE
(State or country)*Baets*

PARENTS

10 NAME OF FATHER

*Andrew White*11 BIRTHPLACE OF FATHER
(State or country)*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER
(State or country)*Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Cassie White

(Address)

225 N. Baretta

15

JUN 10 1915

ROBERT . KRAUTER,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH

June 9, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*June 10, 1915, to June 7, 1915,*that I saw him alive on *June 8, 1915,*and that death occurred, on the date stated above, at *4* a.m.

The CAUSE OF DEATH* was as follows:

*Pulmonary Tuberculosis*Contributory
(SECONDARY)*Pulmonary Hemorrhage*
(Duration) yrs. mos. ds.

(Signed)

John J. ...
(Address) *939 N. Fayette*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount Auburn Cemetery June 12, 1915

20 UNDERTAKER

ADDRESS

Alfred J. ...

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

ST. 18 WARD)

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.

yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

ROBERT KRAUTER,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Premature Birth

Contributory (SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85948

CERTIFICATE OF DEATH.

24
REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4396 Gay ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Mary B. Baldwin

(Residence in Baltimore: No. 4396 Gay St. St.; yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

June 9th, 1915
(Month) (Day) (Year)

7-AGE,

yrs. mos. 7 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

John W. Baldwin

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country),

Richmond, Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary B. Baldwin

(Address) 4396 Gay St.

15-

JUN 10 1915

ROBERT

KRAUTH

Filed.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 9th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 2 1915, to June 9 1915,

that I saw her alive on June 9 1915,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Tetanus (hepatoma)

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Albert E. Baldwin M. D.

June 9, 1915 (Address) 444 Gay St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cemetery

DATE OF BURIAL,

June 10, 1915

20-UNDERTAKER,

Mrs J. E. Evans

ADDRESS

1428 Schuler St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85949

CERTIFICATE OF DEATH

20

C85949

1 PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C.

CITY OF BALTIMORE: (No.

East Monument

St.

15

WARD)

2-FULL NAME

Hilda Schneeberger

(Residence in Baltimore: No.

2006 Walbrook Ave

St.

15th

mo.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RD Dist No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

July 24th

(Month)

(Day)

1896

(Year)

7-AGE

19

3

mos.

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

School-Girl

9-BIRTHPLACE

(State or country)

Balt.

10-NAME OF FATHER

Jacob Schneeberger

11-BIRTHPLACE OF FATHER

(State or country)

New York

12-MAIDEN NAME OF MOTHER

Belle Ohu

13-BIRTHPLACE OF MOTHER

(State or country)

va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jacob Schneeberger

(Address)

2006 Walbrook Ave

15-

JUN 10 1915

ROBERT KRAUTER,

Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

9

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 6, 1915, to, June 9, 1915,

that I saw her alive on June 9, 1915,

and that death occurred, on the date stated above, at 4:15 P.m.

The CAUSE OF DEATH* was as follows:

Streptococci cellulitis of face, originating in pimple on side of face.

Contributory (SECONDARY) Septicaemia

(Signed), M. B. Levin M. B.

June 9, 1915 [Address] Hebrew Hosp

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. 7, ds. 21, mos. 21, ds. 21

Where was disease contracted, 2006 Walbrook Ave

Former or usual residence 2006 Walbrook Ave

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Balt Hebrew Cem

6/10/15

20-UNDERTAKER

ADDRESS

David Soudheim 1180 M Royal Ave

C85950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 C85950

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1642 Millman ST.; 7 WARD)FULL NAME Bessie Scherer (Scherer)Residence in Baltimore: No. 1642 Millman St.; yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, Female 4-COLOR OR RACE, Col. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)6-DATE OF BIRTH, March 13, 1892
(Month) (Day) (Year)7-AGE, 23 yrs. 2 mos. - ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. General
(b) General nature of industry, business, or establishment in which employed (or employer). domestic9-BIRTHPLACE, (State or Country), Md.10-NAME OF FATHER, John Townsend11-BIRTHPLACE OF FATHER (State or Country), Md.12-MAIDEN NAME OF MOTHER, Ann's Mumford13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Townsend(Address) 1642 Millman St.

15- JUN 10 1915

Filed.....

REGISTERED

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 28 1915, to June 8 1915, that I saw him alive on June 8 1915, and that death occurred, on the date stated above, at 8:45 p.m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis
(Duration) yrs. mos. ds.CONTRIBUTORY Cardiac asthma
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. P. Kimball M. D.June 9, 1915 (Address) 614 W. East St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laurel Cemetery June 11, 1915

20-UNDERTAKER

ADDRESS

Charles B. Bailey 1421 Jefferson St.

Cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85951

104

C85951

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. 22*)

WARD

2-FULL NAME

Angelo Agro
105 W Barre St

(Residence in Baltimore: No. *105 W Barre St*)

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX <i>male</i>	4-COLOR OR RACE <i>white</i>	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>single</i>
6-DATE OF BIRTH <i>Nov</i> <i>?</i> <i>1914</i> (Month) (Day) (Year)		
7-AGE <i>7</i> yrs. <i>7</i> mos. <i>0</i> ds. or <i>?</i> min.?		
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <i>child</i>		

PARENTS	9-BIRTHPLACE (State or country) <i>Maryland</i>
	10-NAME OF FATHER <i>Gonairo Agro</i>
	11-BIRTHPLACE OF FATHER (State or country) <i>Russia</i>
	12-MAIDEN NAME OF MOTHER <i>Alfonsina Cassio</i>
	13-BIRTHPLACE OF MOTHER (State or country) <i>Italy</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ar Curry*
(Address) *105 W. Barre St*

15-

FILED 1915

ROBERT KRA...
DEPUTY REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH <i>June</i> <i>9th</i> <i>1915</i> (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I attended deceased from <i>June 3, 1915</i> to <i>June 9, 1915</i> , that I saw him alive on <i>June 9, 1915</i> , and that death occurred, on the date stated above, at <i>11:45 a.m.</i>
The CAUSE OF DEATH* was as follows: <i>Acidosis</i>

Contributory (SECONDARY) <i>Alcoholism</i> (Duration) yrs. mos. ds.
(Signed) <i>G. F. Powers</i> <i>June 9, 1915</i> (Address) <i>105 W. Barre St</i>

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS] At place of death yrs. mos. <i>6</i> In the State yrs. <i>7</i> mos. ds.
Where was disease contracted, if not at place of death? <i>105 W. Barre St</i>
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL <i>St Vincent</i>	DATE OF BURIAL <i>June 10, 1915</i>
20-UNDERTAKER <i>John F. Zaher & Sons</i>	ADDRESS <i>1318 Light St</i>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85952

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85952

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *Pine & Mulberry* ST. *8* 4 WARD) REGISTERED No. C
2-FULL NAME *Clay Perry* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *318 Myrtle Ave* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *Col* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)
6-DATE OF BIRTH, *Nov. 1889* (Month) (Day) (Year)

7-AGE, *32* If LESS than 1 day, yrs. mos. ds.hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.
10-NAME OF FATHER, *William Perry*
11-BIRTHPLACE OF FATHER (State or Country), *Maryland*
12-MAIDEN NAME OF MOTHER, *May I. Wallace*
13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *William Perry*
(Address) *Hent. Co. Md*

51670
Filed *1915* ROBERT KRAUTER
Serial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 8, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Dilatation
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Chronic Hypertension*

(Duration) yrs. mos. ds.

(Signed) *J. H. Bennett* M. D.
(Coroner)

June 9, 1915 (Address) *1314 Carrollton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Hent. Co. Md*

DATE OF BURIAL, *June 11, 1915*

20-UNDERTAKER *Walter Owens*

ADDRESS *2312 Pine St*

C85953

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85953

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1576 Wilmore Alley ST. 91 WARD)

2-FULL NAME

(Residence in Baltimore No. 1576 Wilmore Alley St.: — yrs. 4 mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Colored5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH.

February 8, 1915
(Month) (Day) (Year)

7-AGE.

4 yrs. — mos. — ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....
None9-BIRTHPLACE,
(State or Country),Balto10-NAME OF
FATHER,Mrs Edwards11-BIRTHPLACE
OF FATHER
(State or Country),Balto12-MAIDEN NAME
OF MOTHERKatie Thornton13-BIRTHPLACE
OF MOTHER
(State or Country),Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

Mrs Edwards1576 Wilmore Alley

15-

filed.....

JUN 10 1915

191.....

HARRY O. JENNINGSRegistrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 9, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That, attended deceased from
May 22, 1915, to June 9, 1915,
that, saw him live on June 6, 1915,
and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation.....
(Duration)..... yrs. mos. ds.CONTRIBUTORY
(Secondary)Gravels & Pileup

(Signed)..... M. D.

June 9, 1915 (Address) 1576 Wilmore Alley*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDE, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
SIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

New CathedralJune 10, 1915

20-UNDERTAKER

ADDRESS

Samuel T. Henry 578 E. Redd

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 C85951

PLACE OF DEATH
CITY OF BALTIMORE (No. *Mary Hospital*) St. *4* WARD
2-FULL NAME *Unknown*
(Residence in Baltimore: No. *Unknown* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARKED, WIDOWED, OR DIVORCED, (Write the word.) *Unknown*
6-DATE OF BIRTH, *Unknown* (Month) (Day) (Year)

7-AGE, *about 50* yrs. mos. ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Unknown*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Unknown*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Police Records*

(Address)

15- *JUN 10 1915* HARRY O. ANDREWS, Registrar.

Filed: *Jun 10 1915* Serial: *Permit to Oler*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 31*, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:
apoplexy

(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary) *arterio-sclerosis*

(Duration)yrs.mos.ds.

(Signed) *Thos. H. Chambers* M. D. (Coroner.)

June 7, 191*5* (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.mos.ds. In the State....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *JUN 10 1915*

HOPKINS HOSPITAL

20-UNDERTAKER *Commissioner Health* ADDRESS

FOR ANATOMICAL PURPOSES

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85955

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85955

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1907 n. Tregeste St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 18.)

2-FULL NAME

Baby Wilson

(Residence in Baltimore: No. 1907 n. Tregeste St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

M

4-COLOR OR RACE

W

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

single

6-DATE OF BIRTH

June

8

(Month)

1915

(Day)

(Year)

7-AGE

<

If LESS than

1 day, 2 hrs.

yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

Ind

10-NAME OF FATHER

Joseph Wilson

11-BIRTHPLACE OF FATHER
(State or country)

Ind

12-MAIDEN NAME OF MOTHER

Sophie Fontay

13-BIRTHPLACE OF MOTHER
(State or country)

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

9

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 8, 1915, to, June 9, 1915,

that I saw him alive on June 9, 1915,

and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

Aspiration of fluid + blood

(Duration) yrs. mos. ds.

(Signed),

E. D. Plass

M. D.

June 9, 1915. [Address] J. H. H.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

HARRY O. JOHNS HOPKINS HOSPITAL

JUN 10 1915

Burial Permit 0105 UNDERTAKER Health

ADDRESS

REGISTRAR

FOR ANATOMICAL PURPOSES

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85956

CERTIFICATE OF DEATH.

PLACE OF DEATH

Union Protestant Infirmary

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1514 Division

ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

Mrs. Mary Whitlatch

(Residence in Baltimore: No.

Brooklyn N.Y.

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

December 12, 1872
(Month) (Day) (Year)

7-AGE,

42 yrs. 5 mos. 28 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country)

Connecticut

10-NAME OF FATHER,

Henry Hutchinson

11-BIRTHPLACE OF FATHER

(State or Country),

New York

12-MAIDEN NAME OF MOTHER

Annie Davis

13-BIRTHPLACE OF MOTHER

(State or Country),

Massachusetts

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Marshall Whitlatch

(Address)

110 Prospect Ave

JUN 10 1915

Filed

191

Serial Permb. 0101

Registrar

HARRY O. ANDERSON

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 9, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 26 1915, to June 9 1915,

that I saw her alive on

June 9 1915,

and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:

Sarcoma, retroperitoneal
(Operation June 3, 1915)

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. 3 mos. ds.

(Signed) R. F. Kieffer M. D.

June 9, 1915 (Address) A. P. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 15 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Brooklyn N.Y.

Former or usual residence 110 Prospect Place Brooklyn N.Y.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Brooklyn N.Y.

4-11-1915

20-UNDERTAKER,

ADDRESS

Henry W. Jenkins & Sons Co

William H. Richard

Rto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85957

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85957

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *636 Myrtle*

ST. *21*

WARD)

2-FULL NAME *Lewis V. Stanger*

(Residence in Baltimore: No. *636 Myrtle*

St.: *40* yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

Feb.

27, 1848

(Month)

(Day)

(Year)

7-AGE

67

yrs.

4

mos.

11

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Broom maker

9-BIRTHPLACE

(State or country)

Maryland

10-NAME OF FATHER

John Stanger

11-BIRTHPLACE OF FATHER

(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robt Wacker

(Address)

636 Myrtle

15.

HARRY O. ADAMS,

Barial Permit Officer

REGISTRAR

JUN 10 1915

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

9

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1st

1914

to

June 9th

1915

that I saw him alive on *June 9th* 1915.

and that death occurred, on the date stated above, at *4:20* m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Cerebral softening

(Duration)

yrs.

6

mos.

-

ds

Contributory (SECONDARY)

Hemiplegia

(Duration)

yrs.

-

mos.

-

ds

(Signed)

A. S. Warner M. D.

June 10, 1915

(Address)

320 Highland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence

to the

yrs.

mos.

ds.

State

yrs.

mos.

ds.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Cem

June 12, 1915

20-UNDERTAKER

E. Schlomandson Hanover

ADDRESS

1039

C85958

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85958

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1613 McCulloh* St.; *14* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1613 McCulloh St* St.; *68* yrs., *15* mos., *15* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Jan'y. 14, 1882

(Month)

(Day)

(Year)

7-AGE,

*93**4**mo.*

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. Frank*(Address) *1613 McCulloh St.*

15-

JUN 10 1915

HARRY O. ARTHURS,

Regist.

Serial Permit No. *101*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 9, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 15, 1915*, to *June 9, 1915*,that I saw her alive on *June 7, 1915*,and that death occurred, on the date stated above, at *8:15* m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis(Duration) *1* yrs., *4* mos., *15* ds.CONTRIBUTORY (Secondary) *Cardiac Failure*(Duration) *1* yrs., *4* mos., *15* ds.(Signed) *C. E. Smith* M. D.*June 9, 1915* (Address) *817 Park Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs., *4* mos., *15* ds. In the State *1* yrs., *4* mos., *15* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Ches. Sholam Cem.

DATE OF BURIAL,

6/11, 1915

20-UNDERTAKER

David S. S. S.

ADDRESS

1800 Royal Ave

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85959

CERTIFICATE OF DEATH.

x 36

C85959

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. 9 WARD)2-FULL NAME *Blanche Virginia Kidd*(Residence in Baltimore: No. *St. Joseph's Hospital, Caroline St.* 3 yrs. 4 mos. 11 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *single* (Write the word.)6-DATE OF BIRTH, *March 27, 1887* (Month) (Day) (Year)7-AGE, *28* yrs. *2* mos. *15* ds. If LESS than 1 day,hrs. or....min.8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Graduate Nurse* (b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Frank B. Kidd*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Ella W. Gorsuch*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank B. Kidd*(Address) *Parkton R.F.D. Md.*15- *JUN 11 1915* ROBERT . KRAUTH, *Curial Permit Clerk* Filed.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 11, 1915* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 5* 1915, to *June 11* 1915, that I saw her alive on *June 11* 1915, and that death occurred, on the date stated above, at *5 a.m.*

The CAUSE OF DEATH* was as follows:

Acute Nephritis

.....

.....

..... (Duration) *unknown* yrs. mos. ds.CONTRIBUTORY *Basilar Meningitis?* (Secondary).....

..... (Duration) yrs. mos. ds.

(Signed) *J. W. Vinton* *Cliff* M. D.*June 11, 1915* (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *4* mos. *11* ds. to the *28* yrs. *2* mos. *15* ds. StateWhere was disease contracted, *Unknown* if not at place of death?Former or usual residence *Parkton, Maryland*19-PLACE OF BURIAL OR REMOVAL, *Parkton Md*DATE OF BURIAL, *June 11, 1915*

20-UNDERTAKER

*Ed. Roy Stiffen*ADDRESS *844 W 36th*

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85960

Estella V. Warner.
HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85960

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3442 Hickory Ave.

REGISTERED No. C
13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2 FULL NAME Estella V. Warner

(Residence in Baltimore: No. 3442 Hickory Ave. St. yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)
6 DATE OF BIRTH Dec. 23, 1882
(Month) (Day) (Year)
7 AGE 32 yrs. 5 mos. 17 ds. or min.?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) Balto. City

10 NAME OF FATHER Jessie Sullivan

11 BIRTHPLACE OF FATHER
(State or country) Balto. City

12 MAIDEN NAME OF MOTHER Rebecca Lowe

13 BIRTHPLACE OF MOTHER Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Bessie Warner

(Address) 3442 Hickory Ave.

15 JUN 11 1915 ROBERT . KRAUTER,
Filed 1915 Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 9, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1915, to June 9, 1915, that I saw her alive on 6/7, 1915, and that death occurred, on the date stated above, at 2 P. m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. 1 mos. ds.

Contributory (SECONDARY) Uræmia

(Duration) yrs. mos. ds.

(Signed) Geo. W. Wells, M. D.

June 10, 1915 (Address) 2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Mary's Cemetery H. DATE OF BURIAL June 12, 1915.

20 UNDERTAKER A. S. Marshall 3539 Falls Road ADDRESS

14. b. — Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85961

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85961

CERTIFICATE OF DEATH.

156

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.

Mary Hospital

ST.

24

WARD)

2-FULL NAME

William E. Elliott.

(Residence in Baltimore: No.

1204 Riverside Ave.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. dn.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male.

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH.

July

18

1866

(Month)

(Day)

(Year)

7-AGE,

48

10

mos.

23

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Business.
Stationary engine

9-BIRTHPLACE, (State or Country),

Maryland.

10-NAME OF FATHER,

James B. Elliott.

11-BIRTHPLACE OF FATHER (State or Country),

Id.

12-MAIDEN NAME OF MOTHER

Mary Mc Girth.

13-BIRTHPLACE OF MOTHER (State or Country),

Not known.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Wm. H. Elliott (Son).

(Address).

1410 Marshall St.

15-

JUN 11 1915

ROBERT J. KRAUTER,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

10

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, sa-

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide - Asphyxia - illu-
inating gas.
about 7:30 hours
(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Thos. H. Chambers M. D.

June 10, 1915 (Address) 18 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death....yrs....mos....ds. State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

CEDAR HILL

DATE OF BURIAL

JUN 12, 1915

20-UNDERTAKER

ARMSTRONG-DENNY CO.

ADDRESS

715 Light St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85962

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *432 N. Broadway* ST.; *6* WARD)

FULL NAME

Amelia Witzel(Residence in Baltimore: No. *432 N. Broadway*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *48* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Widow*

6-DATE OF BIRTH,

June 16, 1847
(Month) (Day) (Year)

7-AGE,

67 yrs. *11* mos. *24* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*at Home*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

Julius Pfingstler

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Otto Witzel

(Address)

432 N. Broad.

15- JUN 11 1915

ROBERT KRAUTER,

Filed.

gged

191

MAY 1911 PERMIT OLIVER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 9, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 8 1915 to June 9 1915*that I saw *her* alive on *June 9 1915*and that death occurred, on the date stated above, at *91* m.

The CAUSE OF DEATH* was as follows:

Strenuous Legals
(Cause of Death)

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Broken Compression*
(Duration) yrs. mos. ds.(Signed) *Prof. J. B. Adams* M. D.*110/157*, ID1 (Address) *143 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Holy Redeemer**June 13, 1915*

20-UNDERTAKER

ADDRESS

For J. Herr 1914 C. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85963

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1622 E. Oliver* ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1622 E. Oliver*St.; *70* yrs., *7* mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Married*

6-DATE OF BIRTH,

Nov 10, 1830
(Month) (Day) (Year)

7-AGE,

84 yrs., *7* mos., *10* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Undertaker*
*Retired*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

*John Fink*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Mary Eisenhauer*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Elizabeth Fink

(Address)

1622 E. Oliver St.

15-

JUN 11 1915

ROBERT

KRAUTER

JUN 11 1915

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 9, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *May 1* 191*5*, to *June 8* 191*5*, that I saw him alive on *June 8* 191*5*, and that death occurred, on the date stated above, at *9:45* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach.
(Clinical Diagnosis)
(Duration) *6* yrs., *6* mos., *10* ds.CONTRIBUTORY
(Secondary)*Cancer of Stomach*
(Duration) *6* yrs., *6* mos., *10* ds.(Signed) *Alfred D. Williams* M. D.*June 10, 1915* (Address) *1532 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

June 17, 1915

20-UNDERTAKER

Geo M. Fink

ADDRESS

841 N. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85964

CERTIFICATE OF DEATH.

C85964

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 546 W Biddle ST.; 17 WARD)

2-FULL NAME

Residence in Baltimore: No. 546 W Biddle St St.; 17 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life time
yrs. / mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Widowed

6-DATE OF BIRTH,

Unknown, 1831.
(Month) (Day) (Year)

7-AGE,

84 yrs. / mos. / ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

Physician

9-BIRTHPLACE,

(State or Country),

Baltimore City

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Williams(Address) 546 W. Biddle St.

15-

JUN 11 1915ROBERT . KRAUTERSanial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 7th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 3rd 1915 to June 9th 1915.that I saw him alive on June 8th 1915.and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) 8 yrs. / mos. / ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. / mos. / ds.(Signed) W. H. Hollander M. D.June 7, 1915 (Address) 607 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 84 yrs. / mos. / ds. In the State 17 yrs. / mos. / ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Laurel Cemetery

DATE OF BURIAL,

June 11, 1915

20-UNDERTAKER

George H. Hollander

ADDRESS

517 Robert St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 455 Whitridge Ave ST.; 12 WARD)

2-FULL NAME

(Residence in Baltimore: No. 455 Whitridge Ave St.; 10 yrs., 7 mos., 13 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

Oct 27, 1844
(Month) (Day) (Year)

7-AGE,

70 yrs., 7 mos., 13 ds.If LESS than 1 day, hrs. or mins.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Pa

10-NAME OF FATHER,

Daniel McKarhor

11-BIRTHPLACE OF FATHER (State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Kazia Dobson

13-BIRTHPLACE OF MOTHER (State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Fannie E. Bell(Address) 455 Whitridge

15-

JUN 11 1915 ROBERT KRAUTER,
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 10th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

January 19th 1915 to June 10th 1915,that I saw her alive on June 10th 1915,and that death occurred, on the date stated above, at 930 P m.

The CAUSE OF DEATH* was as follows:

Fibro-sarcoma of uterus
(Clinical Diagnosis)(Duration) 6 yrs., 6 mos., 6 ds.

CONTRIBUTORY (Secondary)

Fibroids of uterus(Duration) 6 yrs., 6 mos., 6 ds.(Signed) Geo. H. Montgomery, M.D.June 10th 1915 (Address) 2537 Guilford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs., 6 mos., 6 ds. In the State 7 yrs., 6 mos., 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Green Mount Cem

DATE OF BURIAL,

June 13, 1915

20-UNDERTAKER

William Cook

ADDRESS

5028 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85966

CERTIFICATE OF DEATH.

104 C85966
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3747 Morley ST.; 20 WARD)

2-FULL NAME

(Residence in Baltimore: No. 3747 Morley St.; yrs. 0 mos. 17 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Dec231914

(Month)

(Day)

(Year)

7-AGE,

yrs. 5mos. 17

ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),Balt

10-NAME OF FATHER,

Unknown11-BIRTHPLACE OF FATHER
(State or Country),Unknown

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

JUN 11 1915

ROBERT KRAUTER,

Filed.....

191...

Burial Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 91915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from
June 4 1915, to June 9 1915,
that I saw him alive on June 9 1915,
and that death occurred, on the date stated above, at 7:10 m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis(Duration).....yrs.....mos. 14 ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Howard W. Jones M. D.June 10, 1915. (Address) Dwight St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

J. PetersJune 11, 1915

20-UNDERTAKER

ADDRESS

W. M. Gauthier1624 N. Key St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85967

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85967

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

Residence in Baltimore: No.

ST. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Cored 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH April 29, 1915 (Month) (Day) (Year)

7-AGE yrs. 1 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Woman

9-BIRTHPLACE (State or country) Balt

10-NAME OF FATHER Isaac A. Hopkins

11-BIRTHPLACE OF FATHER (State or country) Md.

12-MAIDEN NAME OF MOTHER Anna Noah

13-BIRTHPLACE OF MOTHER (State or country) Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaac A. Hopkins

(Address) 1604 Bruce St

15 JUN 11 1915 Filed

ROBERT KRAUTH

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 10, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8, 1915, to June 10, 1915, that I saw him alive on June 8, 1915, and that death occurred, on the date stated above, at 6:50 a.m. The CAUSE OF DEATH* was as follows:

Septic Enteritis (Duration) yrs. mos. 5 ds

Contributory (SECONDARY) (Duration) yrs. mos. ds

(Signed) T. N. ... M. D. June 10, 1915 (Address) 317 N. Carrollton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt Auburn June 11, 1915

20-UNDERTAKER ADDRESS

James H. Dennis 303 Preston

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85968

C85968

CERTIFICATE OF DEATH

PLACE OF DEATH *Maryland General Hospital*
 CITY OF BALTIMORE: (No. *115* ST.; *WARD*)
 FULL NAME *Cecilia Agnes Daniels*
 Residence in Baltimore: No. *603 Canton Ave* St.; *Annapolis Md.* yrs. *1* mos. *1* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*
 4-COLOR OR RACE. *White*
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
 6-DATE OF BIRTH. *Oct 21, 1886*
 (Month) (Day) (Year)
 7-AGE. *38* yrs. *7* mos. *19* da. If LESS than 1 day, hrs. or min.?
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Housewife*
 (b) General nature of industry, business, or establishment in which employed (or employer). *Farmer*

9-BIRTHPLACE, (State or Country). *Maryland*

10-NAME OF FATHER. *Frederick Ames*
 11-BIRTHPLACE OF FATHER (State or Country). *Germany*
 12-MAIDEN NAME OF MOTHER. *Rosa Zimmerman*
 13-BIRTHPLACE OF MOTHER (State or Country). *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lena L. Cook*
 (Address) *Frederick Road, Balt.*

15 JUN 11 1915
 Filed..... 191.....
 ROBERT J. BRAUTER,
 Serial Permit Clerk,
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *June 8, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 7, 1915*, to *June 8, 1915*, that I saw her alive on *June 8, 1915*, and that death occurred, on the date stated above, at *7:30 P. m.*
 The CAUSE OF DEATH* was as follows:

Cholecystitis (Infective)
(Gall Stones 5 years)
 (Duration) yrs. mos. *14* da.

CONTRIBUTORY *Acute Cardiac Dilatation*
 (Secondary)

(Duration) yrs. mos. *1* da.
 (Signed) *William B. Blanchard* M. D.
June 8, 1915 (Address) *Ind. Gen. Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *1* da. In the *11* State *1* yrs. mos. da.

Where was disease contracted, if not at place of death? *Annapolis Ind*

Former or usual residence *Annapolis Ind*

19-PLACE OF BURIAL OR REMOVAL, *Landon Park*

20-UNDERTAKER *Geo A Gerbey*

DATE OF BURIAL *June 11, 1915*

ADDRESS *Balto & Hager*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85969

C85969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 W Franklin ST., 19 WARD)

REGISTERED No. C

2-FULL NAME

Marie Estelle Foster

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. 1709 W. Franklin St., Life time yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH

July 24, 1893
(Month) (Day) (Year)

7-AGE,

21 yrs. 11 mos. 15 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Stenographer

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Wm C Foster

11-BIRTHPLACE OF FATHER

(State or Country),

Kentucky

12-MAIDEN NAME OF MOTHER

Emma V Keene

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Emma V Foster

(Address)

1709 W Franklin St

15-

Filed

JUN 11 1915

ROBERT

KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 9, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 6, 1913, to June 9, 1915,

that I saw her alive on June 9, 1915,

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) M. D.

June 11, 1915. (Address) 108 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted,

if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Cathedral Cem

June 12 1915

20-UNDERTAKER

Geo. A. Gerbig

ADDRESS

Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85970

CERTIFICATE OF DEATH.

49 C85970

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

519 East 44

ST.; 5 WARD)

REGISTERED NO. C

2-FULL NAME

Lucy Williams

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

519 East

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Widow

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

60

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

General

(b) General nature of industry, business, or establishment in which employed (or employer).

domestic

9-BIRTHPLACE, (State or Country),

N. C.

PARENTS.

10-NAME OF FATHER,

John Brunt

11-BIRTHPLACE OF FATHER (State or Country),

N. C.

12-MAIDEN NAME OF MOTHER

Mary Brunt?

13-BIRTHPLACE OF MOTHER (State or Country),

N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Brown

(Address) 1709 Ashland Ave

15-

ROBERT KRAUTER,

JUN 11 1915

BALTIMORE PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1, 1915, to June 10, 1915,

that I saw her alive on June 10, 1915,

and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Lott, M. D.

1915 (Address) 611 N. Caroline St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Asbury Cemetery

June 13, 1915

20-UNDERTAKER

ADDRESS

Robt. A. Elliott 506 East St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85971

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

ROBERT KRAUTER,

Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on June 10 1915, and that death occurred, on the date stated above, at 12 AM.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

CONTRIBUTORY (Secondary) Diabetic Gangrene

(Duration) 2 yrs. 2 mos. 11 da.

(Signed) H. H. Wagner M. D.

June 10, 1915. (Address) St. Joseph's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 37 ds. In the 86 yrs. mos. ds.

Where was disease contracted, if not at place of death? Bellair End

Former or usual residence Bellair End X

19-PLACE OF BURIAL OR REMOVAL, Churchville Md

DATE OF BURIAL, June 11, 1915

20-UNDERTAKER, James B. Ayres

ADDRESS, 514 W. Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85972

C85972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *419ⁿ Pearl*ST.: *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *infant of Bertie Taylor*(Residence in Baltimore: No. *419 Pearl*

St.: yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

IF LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILE

JUN 11 1915

ROBERT . KRAUTER
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 11, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *June 7, 1915* to *June 11, 1915*, that I saw him alive on *June 10, 1915*, and that death occurred, on the date stated above, at *3 a.m.*

The CAUSE OF DEATH* was as follows:

congenital dilatation
(Duration) yrs. mos. da.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) *N. N. Taylor* M. D.191... (Address) *102 E. Mulberry St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Auburn Cemetery**June 11, 1915*

UNDERTAKER

ADDRESS

Felix B. Prye *102 E. Mulberry St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85973

94 C85973

CERTIFICATE OF DEATH.

1—PLACE OF DEATH

CITY BALTIMORE: (No. 1210 W. Mulberry ST.) 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Christian Rossler

Residence in Baltimore: No. 1210 W. Mulberry

St.: 75 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3—SEX, Male; 4—COLOR OR RACE, White; 5—SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widower (Write the word.)

6—DATE OF BIRTH, Nov. 12th, 1826 (Month) (Day) (Year)

7—AGE, 88 yrs., 6 mos., 30 da. If LESS than 1 day, hrs. or min.?

8—OCCUPATION: (a) Trade, profession, or particular kind of work, Barber; (b) General nature of industry, business, or establishment in which employed (or employer), Retired

9—BIRTHPLACE, (State or Country), Germany

10—NAME OF FATHER, Unknown

11—BIRTHPLACE OF FATHER (State or Country), Germany

12—MAIDEN NAME OF MOTHER, Unknown

13—BIRTHPLACE OF MOTHER (State or Country), Germany

14—THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Henry C. Snierien

(Address), 1210 W. Mulberry St.

15—JUN 12 1915, ROBERT KRAUTER, Registrar.

Filed....., 191... Serial Permit Order

MEDICAL CERTIFICATE OF DEATH.

16—DATE OF DEATH, June 11th, 1915 (Month) (Day) (Year)

17—I HEREBY CERTIFY, That I attended deceased from June 3, 1915, to June 10, 1915, that I saw him alive on June 10, 1915, and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

CONTRIBUTORY (Secondary), Cardiac Weakness

(Duration) yrs. mos. 2 da.

(Signed), A. S. Driscoll M. D.

June 11, 1915 (Address), 512 N. Carrollton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18—LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19—PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

London Park Cemetery June 13th, 1915

20—UNDERTAKER, ADDRESS

Messrs. John H. Seufel & Co. 201 E. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

50 C85975

PLACE OF DEATH

CITY OF BALTIMORE (No. 132 Jackson Place ST. 6 WARD)

FULL NAME Mary M. C. Cramer Stromenger

(Residence in Baltimore: No. 132 Jackson Pl. St. — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow (Write the word)

6-DATE OF BIRTH March 13, 1842 (Month) (Day) (Year)

7-AGE 73 yrs. 7 mos. 28 ds. If LESS than 1 day, — hrs. or — min. ?

8-OCCUPATION (a) Trade, profession, or particular kind of work house work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Maryland.

10-NAME OF FATHER Nathan Nelson

11-BIRTHPLACE OF FATHER (State or country) unknown

12-MAIDEN NAME OF MOTHER Penelope Slade

13-BIRTHPLACE OF MOTHER (State or country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Stromenger

(Address) 132 Jackson Place

JUN 12 1915

HARRY O. ARTHUR, Registrar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 10, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1914, to June 10, 1915, that I saw her alive on June 10, 1915, and that death occurred, on the date stated above, at 119 m.

The CAUSE OF DEATH* was as follows: Diabetes mellitus

Contributory (SECONDARY) Chronic nephritis (Duration) 7 yrs. — mos. — ds. (Signed) Alfred Pallack M. D. June 10, 1915 (Address) 1112 Eutan St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds. Where was disease contracted, If not at place of death? — Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lorraine Cemetery

June 12, 1915

20-UNDERTAKER

ADDRESS

H. E. Hughes

17 S. Broadway

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85973

HEALTH DEPARTMENT--CITY OF BALTIMORE

C85973

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No

WARD)

2-FULL NAME

(Residence in Baltimore: No

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10 NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

15-

HARRY O. ADAMS

Serial Permit No.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from Jan 15, 1915, to June 10, 1915,

that I saw him alive on June 10, 1915, and that death occurred, on the date stated above, at 11:00 m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed),

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. 5 mos. 3 ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100

C85977

1 PLACE OF DEATH
CITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *18* WARD)
2 FULL NAME *Edna Friedman*
(Residence in Baltimore: No. *209 N. Arlington Ave.* ST. *5* yrs. *—* mos. *—* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *Single*
6-DATE OF BIRTH *Unknown* 1907
7-AGE *8* yrs. *—* mos. *—* ds. or *1* day, *—* hrs., *—* min.?
8-OCCUPATION *School Girl*

9-BIRTHPLACE (State or country) *Balto Md.*

PARENTS
10-NAME OF FATHER *Benjamin Friedman*
11-BIRTHPLACE OF FATHER (State or country) *Russia*
12-MAIDEN NAME OF MOTHER *Fannie Foreman*
13-BIRTHPLACE OF MOTHER (State or country) *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Ben Friedman*
(Address) *209 N. Arlington Ave.*

15-*JUN 13 1915*
FIM *191*
HARRY O. ANDREWS,
Serial Permit Clerk,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 11* 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 10*, 1915, to *June 11*, 1915, that I saw her alive on *June 11*, 1915, and that death occurred, on the date stated above, at *12:40 P.M.*

The CAUSE OF DEATH* was as follows:

*Edema of Glottis
following Laryngectomy*

Enlarged tonsils (Duration) *1* mo. *1* ds.

Contributory (SECONDARY) *M. B. Levine* M. D.

(Signed) *June 11*, 1915 [Address] *Hebrew Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *1* mo. *1* ds. State *8* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death? *Hebrew Hospital*

Former or usual residence *209 N. Arlington Ave.*

19-PLACE OF BURIAL OR REMOVAL *Hebrew Mt. Carmel* DATE OF BURIAL *June 11* 1915

20-UNDERTAKER *S. Lennson & Bro* ADDRESS *1107 E Baltimore*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85978

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85978

PLACE OF DEATH

CITY OF BALTIMORE (No. *1315 Linden Ave* ST. *11* WARD)

FULL NAME *Elizabeth Freder Guenther*

(Residence in Baltimore: No. *1315 Linden Ave* St. *11* yrs. *2* mos. *2* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill on No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

1 SEX *Female* 4 COLOR OR RACE *white* 5 SINGLE, *single* MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH *June 9, 1915* (Month) (Day) (Year)

7 AGE *1* yrs. *1* mos. *2* ds. or *2* min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *none* (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *13 Atlantic City*

10 NAME OF FATHER *Albert Guenther*

11 BIRTHPLACE OF FATHER (State or country) *City*

12 MAIDEN NAME OF MOTHER *O'Connor*

13 BIRTHPLACE OF MOTHER (State or country) *Ireland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Albert Guenther*

(Address) *1315 Linden Ave.*

15 JUN 12 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *June 11, 1915* (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *June 9, 1915*, to *June 11, 1915*, that I saw her alive on *June 11, 1915*, and that death occurred, on the date stated above, at *2:30 p.m.*

The CAUSE OF DEATH* was as follows: *premature birth, preg- nancy 6 months, general debility*

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) *W. A. B. Sellman* M. D. (Address) *5 E. Biddle St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Balt Cem* DATE OF BURIAL *6/12/15*

20 UNDERTAKER *Chas. J. Evans* ADDRESS *118 Wm. T. Rayal Ave*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85979

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *906 E North Ave*)

ST.:

WARD)

79
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME *Thomas J Collins*

(Residence in Baltimore: No. *906 E North Ave*)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)

6-DATE OF BIRTH, *July 17th, 1873*
(Month) (Day) (Year)

7-AGE, *41* yrs. *10* mos. *24* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Salesman*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *MD*

10-NAME OF FATHER, *Peter Collins*

11-BIRTHPLACE OF FATHER (State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER *Mary O'Connor*

13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Collins*

(Address) *906 E. North Ave*

15-
JUN 12 1915

HARRY O. ANDREWS,

101 Serial Permit Clerk
Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 17th, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary).....

(Duration) yrs. mos. ds.

(Signed) *Elyse J. Russell* M. D.
(Coroner.)

July 11th, 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Cathedral Cem*

DATE OF BURIAL, *6/14*, 1915

20-UNDERTAKER *Chas. F. Evans*

ADDRESS *148 Wm. Royal Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85980

C85980

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1520 Covington* ST.; *24* WARD)

FULL NAME

(Residence in Baltimore: No. *1520 Covington* St.; *Life time* mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

Jan 1st, 1861
(Month) (Day) (Year)

7-AGE,

54 yrs. 5 mos. 10 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Boilermaker
B & O R. R.*

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Richard M. Kelly

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary A O'Neill

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Catherine Kelly*(Address) *1520 Covington St*

16-

*JUN 12 1915**HARRY O. ANDREWS,*

Filed... 191... Serial Form 15. 01... Registrar.

MEDICAL CERTIFICATE OF DEATH.

15-DATE OF DEATH,

June 11, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1, 1913*, to *Jun 11, 1915*,that I saw him alive on *June 10, 1915*, and that death occurred, on the date stated above, at *8 A* m.

The CAUSE OF DEATH* was as follows:

*Cerebral Hemorrhage*CONTRIBUTORY (Secondary) *Cardiac asthma*(Signed) *R. E. Campbell* M. D.
Jun 11, 1915 (Address) *1644 N. Howard St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Catholic Cemetery *June 14, 1915*

20-UNDERTAKER

ADDRESS

F. A. Krause *703 N. Howard*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85981

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85981

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

1605 W. Lombard.

St.:

WARD)

2-FULL NAME

Emma Clark

(Residence in Baltimore: No.

1605 W. Lombard

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St. *Lifetime* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

June

22,

1868

(Month)

(Day)

(Year)

7-AGE,

46

yrs.

11

mos.

19

ds.

If LESS than 1 day,

hrs. or

min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(h) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Balto Md.

10-NAME OF FATHER,

Isaac Hussey

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Ann Clark

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Annie McDonnell

(Address)

1605 W. Lombard St.

15-

JUN 12 1915.

HARRY O. ANDREWS,

Filed

191

Burial Permit No.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

10th, 1915.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Saint Vincent

(Coroner)

June 11th, 1915. (Address) 2302 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Peters Church

June 12, 1915

20-UNDERTAKER

Cook

ADDRESS

1003 W. Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1726 Patapsco* ST.; *23* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Fabrice Morrison*(Residence in Baltimore: No. *1726 Patapsco* St.; *35* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Married*

6-DATE OF BIRTH,

Unknown, 1840

(Month)

(Day)

(Year)

7-AGE,

70

yrs. mos. ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Fireman
Rug Boat*9-BIRTHPLACE,
(State or Country),*Ireland*10-NAME OF
FATHER,*Patrice Morrison*11-BIRTHPLACE
OF FATHER
(State or Country),*Ireland*12-MAIDEN NAME
OF MOTHER*Catherine Cunningham*13-BIRTHPLACE
OF MOTHER
(State or Country),*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. M. Morrison

(Address)

1726 Patapsco

15-

JUN 12 1915

HARRY O. ANDREWS,

Baptist. Permit. Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 10, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 5 1915 to *June 10 1915*,that I saw him alive on *June 10 1915*,and that death occurred, on the date stated above, at *3 A. m.*

The CAUSE OF DEATH* was as follows:

*Carcinoma of Rectum**(Clinical Diagnosis)**(Duration) yrs. 3 mos. ds.*CONTRIBUTORY (Secondary) *Exhaustion**(Duration) yrs. 6 mos. ds.*Signed) *R. P. Campbell* M. D.*June 11, 1915* (Address) *1644 Leander*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*Baptist Cemetery*DATE OF BURIAL, *June 12, 1915*

20-UNDERTAKER,

*D. M. F. Lynn*ADDRESS *1422 Light*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170

C85983

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1923 Light*ST.: *23* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Charles F. Thompson*(Residence in Baltimore: No. *1923 Light*

St.: — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Oct 16, 1864
(Month) (Day) (Year)

7-AGE,

48 yrs. *7* mos. *25* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...*Clerk*
Office

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER,

Joseph Thompson

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Susan Knapp

13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. John I. Knapp*(Address) *1923 Light St.*

15-

File

JUN 12 1915

HARRY O. ANDREWS,

Barial. Permit. Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 11, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1, 1915, to *June 11, 1915*,that I saw him alive on *June 11, 1915*,and that death occurred, on the date stated above, at *9 A* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) *1* yrs. *1* mos. *10* ds.

CONTRIBUTORY (Secondary)

Uremia(Duration) *10* yrs. *10* mos. *10* ds.(Signed) *R. R. Campbell* M. D.*June 11, 1915* (Address) *1644 Hancock St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *10* ds. In the State *1* yrs. *1* mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Green Mount Cemetery *June 14, 1915*

20-UNDERTAKER

ADDRESS

*D. M. Flynn**1422 Light St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

085984

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

92

085984

1-PLACE OF DEATH

REGISTERED NO. C.

CITY BALTIMORE: (No. 4009 Maine Ave. ST. 20 WARD)

2-FULL NAME

John H. Schmeuner

(Residence in Baltimore: No.

4009 Maine Ave.

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-MARRIED

Married

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

Oct 30, 1863.

7-AGE

51 yrs. 7 mos. 10 ds. or min.?

If LESS than

1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Butcher

9-BIRTHPLACE
(State or country)

Balto Md.

10-NAME OF FATHER

John H. Schmeuner

11-BIRTHPLACE OF FATHER
(State or country)

Balto Md.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. H. Schmeuner

(Address) 4009 Maine Ave

15-

JUN 12 1915

ROBERT . KRUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 9, 1915

17- I HEREBY CERTIFY, That I attended deceased from

June 6, 1915 to June 9, 1915,

that I saw him alive on June 9, 1915,

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

Contributory Pneumonia on the basis of malarial fever

(SECONDARY) and pulmonary edema

(Duration) yrs. mos. ds.

(Signed) M. J. Schmeuner M. D.

June 9, 1915 [Address] Germantown - Lanore

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green Mount

June 13, 1915

20-UNDERTAKER

ADDRESS

Butt. Mitchell Co. 1201 N. Fayette

C85985 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 N Mount ST.; 16 WARD)2-FULL NAME George Albert Hurley(Residence in Baltimore: No. 1034 N Mount St.; 4 yrs., 4 mos., 4 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)Single

6-DATE OF BIRTH.

June 20, 1910
(Month) (Day) (Year)

7-AGE.

4 yrs., 11 mos., 22 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country).Balto

10-NAME OF FATHER.

Luther D Hurley

11-BIRTHPLACE OF FATHER.

(State or Country).

Balto

12-MAIDEN NAME OF MOTHER.

Mary J. Louis

13-BIRTHPLACE OF MOTHER.

(State or Country).

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Luther D Hurley(Address) 1034 N Mount

15-

Filed

JUN 12 1915ROBERT J. KRAUTH

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 12, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 2, 1915, to June 12, 1915, that I saw him alive on June 11, 1915, and that death occurred, on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH* was as follows:

Heart was found L-
Coronary Artery
(Duration)....yrs....mos....ds.CONTRIBUTORY
(Secondary)(Signed) Winston L. Deane M. D.
June 12, 1915 (Address) 1034 N Mount

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Western View

DATE OF BURIAL.

June 12, 1915

20-UNDERTAKER

William Cook

ADDRESS

522 N. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1109 N Gilmore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85986

CERTIFICATE OF DEATH

REGISTERED No. C.

C85986

PLACE OF DEATH

CITY OF BALTIMORE: (No.

3-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.,
..... yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

FILED

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on 1915, and that death occurred, on the date stated above, at p.m.

The CAUSE OF DEATH* was as follows:

Intestinal Intoxication

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed), M. D.
June 11, 1915 [Address]
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence W. Va.

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85988

C85988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2411 E. Oliver* ST.: *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2411 E. Oliver* St.: *45* yrs. *8* mos. *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

Sept 30th, 1869
(Month) (Day) (Year)

7-AGE.

45 yrs. *8* mos. *11* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

*Saleslady*9-BIRTHPLACE,
(State or Country).*Md*10-NAME OF
FATHER.*Chas. Von Newkirk*11-BIRTHPLACE
OF FATHER

(State or Country).

*Md*12-MAIDEN NAME
OF MOTHER*Rebecca*13-BIRTHPLACE
OF MOTHER

(State or Country).

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Ida V. Wright

(Address).

2411 E. Oliver St.

15-

*ROBERT . KRAUTER,**JUN 12 1915* *Burial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

6 *10*, *1915*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
May 29th 1915 to *June 10th 1915*,
that I saw him alive on *June 10* *1915*
and that death occurred, on the date stated above, at *8 30 P.* m.

The CAUSE OF DEATH* was as follows:

Acute Infectious Nephritis(Duration) yrs. mos. *29* ds.CONTRIBUTORY
(Secondary)*Just Knew*

(Duration) yrs. mos. ds.

(Signed) *Edmund M. Drell* M. D.*June 11, 1915.* (Address) *2016*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Baltimore**June 13, 1915*

20-UNDERTAKER

ADDRESS

*Philip Herwig**2016*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85989

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85989

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2704 Elliott ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2704 Elliott St St.; 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, May 10, 1870
(Month) (Day) (Year)7-AGE, 35 yrs. 1 mos. 1 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Labourer
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Russia Poland10-NAME OF FATHER, not known11-BIRTHPLACE OF FATHER (State or Country), Russia Poland12-MAIDEN NAME OF MOTHER Not known13-BIRTHPLACE OF MOTHER (State or Country), Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Korytkowski(Address) 2704 Elliott

15-

ROBERT . KRAUTH

JUN 12 1915

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from June 9, 1915 to June 11, 1915, that I saw him alive on June 9, 1915, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs
(Duration) 1 yrs. 1 mos. 1 ds.CONTRIBUTORY.....
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) H.B. Titlow M. D.June 11, 1915 (Address) 3031 O'Donnell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Stanislaus Church June 14, 1915

UNDERTAKER ADDRESS

Stephen J. Frachowski 1019 2nd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C85990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 C85990

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 162 W. Dolphin

ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Hall

(Residence in Baltimore: No. 162 W. Dolphin

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX

male

4-COLOR OR RACE

black

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

Nov 14, 1877

(Month) (Day) (Year)

7-AGE

37 yrs. - mos. - ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer)

Local express driver

9-BIRTHPLACE

(State or country)

md

10-NAME OF FATHER

Wennis Hall

11-BIRTHPLACE OF FATHER

(State or country)

md

12-MAIDEN NAME OF MOTHER

Whittington (Martha E.)

13-BIRTHPLACE OF MOTHER

(State or country)

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ann B. Hall

(Address)

162 Dolphin St

15.

Filed

JUN 12 1915

ROBERT KRAUTER,

REGISTRAR

16-DATE OF DEATH

June 9, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 1914, to June 9, 1915,

that I saw him alive on May 27, 1915,

and that death occurred, on the date stated above, at 10:50 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

short

(Duration) 1 yrs. - mos. - ds.

Contributory

(SECONDARY) exposure -

(Duration) - yrs. - mos. - ds.

(Signed),

G. Lane Partridge

M. D.

June 9, 1915 (Address) 1108 Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laurel Green

June 18, 1915

20-UNDERTAKER

ADDRESS

Samuel T. Newbury

578 W. Biddle

HEALTH DEPARTMENT—CITY OF BALTIMORE

C85991

CERTIFICATE OF DEATH.

REGISTERED NO. C

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

Mc General Hospital ST. 15 WARD)

2. FULL NAME

Herbert J Thompson

(Residence in Baltimore: No.

1457 Parry St.

St.; yrs.; mos.; da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Negro

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH,

unknown, 1

(Month)

(Day)

(Year)

7-AGE,

5

yrs.

?

mos.

?

da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

School Boy

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Herbert Thompson

11-BIRTHPLACE OF FATHER

(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Martha Green

13-BIRTHPLACE OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Martha Thompson

(Address).

1457 Parry St.

15-

ROBERT

KRAUTER

Burial Permit Officer

Registrar.

JUN 13 1915

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 10, 1915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 5, 1915, to June 10, 1915, that I saw him alive on June 10, 1915, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) ? yrs. ? mos. 5 da.

CONTRIBUTORY (Secondary)

Pulmonary Tuberculosis

(Duration) ? yrs. ? mos. ? da.

(Signed) William H. Hancher

M. D.

191... (Address) 1457 Parry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 0 yrs. 0 mos. 5 da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence 1457 Parry St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn

June 13, 1915.

20-UNDERTAKER

ADDRESS

James H. Dennis 1000 Lexington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C85992

91 C85992
REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp 3*)

WARD)

2-FULL NAME *David Morgan*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1019 Watson St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

September 12, 1865

(Month)

(Day)

(Year)

7-AGE

49

yrs.

mos.

ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9-BIRTHPLACE
(State or country)

Delaware

10-NAME OF FATHER

David Morgan

11-BIRTHPLACE OF FATHER
(State or country)

md.

12-MAIDEN NAME OF MOTHER

Matilda Blake

13-BIRTHPLACE OF MOTHER
(State or country)

md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. Phelps

(Address)

Johns Hopkins Hosp

15-JUN 12 1915

ROBERT . KRAUTER

Filed

1915

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 11, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 4, 1915, to June 11, 1915,

that I saw him alive on *June 11, 1915,*

and that death occurred, on the date stated above, at *3:15 p.m.*

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration)

yrs.

mos.

7 ds.

Contributory
(SECONDARY)

Chronic meningitis

(Duration)

yrs.

mos.

? ds.

(Signed)

Starke B. Jones

June 11, 1915

[Address]

Johns Hopkins Hosp

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

1019 Watson St.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Auburn Cemetery

June 14, 1915

20-UNDERTAKER

Geo. N. Holland

ADDRESS

517 Robert St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

085993

154
REGISTERED NO. C.

085993

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 115n W York St

ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Boone

Residence in Baltimore: No. 115 W York St

St.; yrs., (16) mos. da)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, Colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Unknown
(Write the word.)

6-DATE OF BIRTH, Unknown, 1817
(Month) (Day) (Year)

7-AGE, 98
If LESS than 1 day, yrs. mos. ds. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (State or Country), Unknown
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Matthews

Address 1430 Mosher St

15- JUN 12 1915 ROBERT KRAUTH

Filed 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senile Decay

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. Matthews M. D.
(Coroner.)

June 12 1915 (Address) 517 Scott St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL.

20-UNDERTAKER ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 MARRIAGE

WIDOWED

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

June 7, 1915, to June 11, 1915, that I saw her alive on June 11, 1915, and that death occurred, on the date stated above, at 10:45 p. m.

The CAUSE OF DEATH* was as follows:

The Infirmitas of Old Age

Contributory
(SECONDARY)

(Signed)

John Hood, M. D.
(Address) 630 N. Gilman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Ann's Cemetery
Annapolis Md

June 14, 1915

20 UNDERTAKER

George J. Smith

ADULTS
J. J. Smith

15 JUN 12 1915

Filed, 191

ROBERT . KRAUTER
Burial Permit Clerk

REGISTRAR

C85995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C85995

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1419 Orleans St.* ST.; *5* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No. *1419 Orleans St.* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE,

Single

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

....., *1*
(Month) (Day) (Year)

7-AGE,

14

If LESS than 1 day,

..... hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed..... 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

....., *June 11*, 191*5*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 1 191*5*, to *June 11* 191*5*,that I saw him alive on *June 9* 191*5*,and that death occurred, on the date stated above, at *3* p. m.

The CAUSE OF DEATH* was as follows:

*Apoplexy & 2nd stroke**insufficiency*

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary).....

3 months (Duration)..... yrs. mos. ds.

(Signed)..... M. D.

191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 12 1915

ROBERT

KRAUTER

RECEIVED

R & Sons 1405 Meade St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

ST. 10 WARD)

FULL NAME

Residence in Baltimore: No.

St. 19 yrs. 7 mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single
6-DATE OF BIRTH Nov. 9, 1895
(Month) (Day) (Year)

7-AGE 19 yrs. 7 mos. - ds. or min. 7
If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession, or particular kind of work Worked in an Clerk. (b) General nature of industry, business, or establishment in which employed (or employer) Engraving establishment

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

JUN 12 1915

ROBERT KRAUT

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Jan 23, 1915, to June 10, 1915.

that I saw her alive on June 10, 1915.

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Contributory (SECONDARY) (Duration) yrs. 5 mos. ds.

(Signed) Gustav H. Wolfenbarger, M. D.

June 11, 1915 (Address) 1210 Guilford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore

June 13, 1915

20-UNDERTAKER

ADDRESS

E. C. Thedfeld 914 E. Lombard Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

085997

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

ST. 17 WARD

St. 23 yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH

AGE

If LESS than
1 day. — hrs.
or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
(State or country)

NAME OF FATHER

BIRTHPLACE OF FATHER
(State or country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(State or country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

JUN 13 1915

REPORT . KRAUTER,

Medical Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

(X Ray + Stomach Liner)
Carcinoma of the Cardiac
end of the Stomach

Contributory
(SECONDARY)

(Signed)

June 12, 1915 (Address) 1718 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in cases from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact name of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C85998

CERTIFICATE OF DEATH

151 C85998

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

St.:

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.:

yrs.

mos.

da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

June 12, 1915

7-AGE

If LESS than 1 day, 1 hrs. or 25 min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Baltimore Md.

10-NAME OF FATHER

Wm. J. Hall

11-BIRTHPLACE OF FATHER (State or country)

City of Baltimore

12-MAIDEN NAME OF MOTHER

Freda G. Hall

13-BIRTHPLACE OF MOTHER (State or country)

City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. J. Hall
1846 Calverton

15-

JUN 13 1915

ROBERT K. KRUTER,
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 12, 1915

17- I HEREBY CERTIFY, That I attended deceased from

June 12, 1915 to June 12, 1915
that I saw him live on June 12, 1915
and that death occurred, on the date stated above, at 8:30 a.m.
The CAUSE OF DEATH* was as follows:

Pneumonia B. R. 6 mos

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery June 13, 1915

20-UNDERTAKER

ADDRESS

Henry Gatz 1007 N. Bond St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1520 Bussman*ST. *15* WARD)

REGISTERED NO. C

2-FULL NAME *Helen Barnes*(Residence in Baltimore: No. *1520 Bussman*St. *1* yrs. *6* mos. *4* ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) *Single*6-DATE OF BIRTH, *January 2, 1915*

(Month)

(Day)

(Year)

7-AGE, *1 yr. 6 mos.*yrs. *6* mos. *4* ds.

If LESS than 1 day,hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Infant*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Balto City*10-NAME OF FATHER, *James H. Barnes*11-BIRTHPLACE OF FATHER (State or Country), *Ind*12-MAIDEN NAME OF MOTHER *Mary Shunk*13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James H. Barnes*(Address) *1520 Bussman St.*

15-

Filed.....

JUN 13 1915

ROBERT KRAUTER
Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 12, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *1-21* 1915, to *June 2* 1915,that I saw her alive on *June 11* 1915, and that death occurred, on the date stated above, at *3:45 p.m.*

The CAUSE OF DEATH* was as follows:

Lobar pneumonia(Duration).....yrs. *1* mos. *4* ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs. *1* mos. *4* ds.(Signed).....*May 10, 1915* M. D.*6-12*, 1915 (Address).....*1520 Bussman St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *4* ds. In the State yrs. *1* mos. *4* ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *St. Peter's*DATE OF BURIAL, *June 13, 1915*20-UNDERTAKER *James H. Barnes*ADDRESS *364 Mary*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.; 18 WARD)

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

June 10, 1915, to June 11, 1915,

that I saw her alive on June 11, 1915,

and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
about (Duration) yrs. 14 mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. 14 mos. ds.

(Signed) Edward P. Smith M. D.

June 11, 1915 (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. 1 mos. 1 ds. In the State yrs. 14 mos. ds.

Where was disease contracted if not at place of death? 1013 Vine St

Former or usual residence 1013 Vine St

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mount Auburn June 15, 1915

20-UNDERTAKER

ADDRESS

John H. Owen 1212 E. ...

14. a.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15-

FILED

JUN 13 1915

ROBERT KRAUTH

JUN 13 1915

Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1716 S. Charles St. ST. 23 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Margaret May Hughes
(Residence in Baltimore: No. 1716 S. Charles St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Single MARRIED WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH May 31, 1915 (Month) (Day) (Year)
7-AGE yrs. mos. 12 ds. or min. 1 day, hrs. min. ? If LESS than 1 day, hrs. min. ?
8-OCCUPATION (a) Trade, profession or particular kind of work Home. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Balt. Md.

PARENTS

10-NAME OF FATHER

David Hughes

11-BIRTHPLACE OF FATHER (State or country)

Balt. Md.

12-MAIDEN NAME OF MOTHER

Anne Laughman

13-BIRTHPLACE OF MOTHER (State or country)

Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David Hughes

(Address)

1716 S. Charles St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 12, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from May 31, 1915, to, June 12, 1915, that I saw her alive on June 12, 1915, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(Duration) yrs. mos. ds. 10 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds. 10 ds.

(Signed)

J. E. Smith
June 12, 1915 [Address] 900 Lexington St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Lawn Cem.

6/13, 1915

20-UNDERTAKER

ADDRESS

J. F. McCall

39 E. Fort

JUN 13 1915

JOHN H. KRAUTER
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1011 Watson*)

2-FULL NAME

*Ethel Meyerowitz*Residence in Baltimore: No. *1011 Watson*

REGISTERED NO. C

ST. *3*

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *1* yrs. *9* mos. *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

*Sept.**2**1913*

(Month)

(Day)

(Year)

7-AGE,

1 yrs. *9* mos. *11* ds.

If LESS than 1 day.

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Jacob Meyerowitz*11-BIRTHPLACE OF FATHER
(State or Country),*Russia*

12-MAIDEN NAME OF MOTHER

*Mollie Gordon*13-BIRTHPLACE OF MOTHER
(State or Country),*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jacob Meyerowitz(Address) *1011 Watson St.*

15-

JUN 13 1915

ROBERT A. KRAUTER

MUNICIPAL DEPT. CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*June**12**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Dec.**1913*

, to

*June 13**1915*

that I saw her alive on

*June 12**1915*and that death occurred, on the date stated above, at *9 A.* m.

The CAUSE OF DEATH* was as follows:

Chronic Meningitis(Duration) *18* yrs. *6* mos. *18* ds.CONTRIBUTORY
(Secondary)(Duration) *6* yrs. *6* mos. *18* ds.(Signed) *Isaac R. Casch* M. D.*June 13, 1915* (Address) *1713 E. Baltimore St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*Workmen Circle Cemetery**6/13, 1915*

20-UNDERTAKER

ADDRESS

*Jack Lewis**1419 E. Baltimore*

16- Every item of information shown on this certificate should be stated exactly. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1013 Somerset* ST.; *10* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1013 Somerset*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *6* yrs., *6* mos. *9* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

*Dec.**3rd**1853*

(Month)

(Day)

(Year)

7-AGE.

*61**6**9*

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Woodworker

9-BIRTHPLACE,

(State or Country).

Baltimore

10-NAME OF FATHER.

Joseph Siegelman

11-BIRTHPLACE OF FATHER

(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Mary Traeg

13-BIRTHPLACE OF MOTHER

(State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Susanna Siegelman

(Address)

1013 Somerset

15-

JUN 13 1915.

ROBERT KRAUTER

Filed

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June

(Month)

12th

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 12th 1915*that I saw him alive on *June 12th 1915*and that death occurred, on the date stated above, at *20 P.*

The CAUSE OF DEATH* was as follows:

Susceptibility to Neutral Venous(Duration) *2* yrs. *6* mos. *9* da.

CONTRIBUTORY (Secondary)

(Duration) *2* yrs. *6* mos. *9* da.

(Signed)

Ed. J. Haver

M. D.

June 12th 1915 (Address) *1301 E. Eager*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

Holy Redeemer Church

20-UNDERTAKER

ADDRESS

Henry Haver & Son 1301 E. Eager

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 614 W. Hamburg ST., 2 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 614 W. Hamburg ST. 48 yrs., 6 mos., 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

June 6, 1867
(Month) (Day) (Year)

7-AGE,

48

yrs. 6 mos. 6 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None.

9-BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Augustus Smith

11-BIRTHPLACE OF FATHER (State or Country),

don't know

12-MAIDEN NAME OF MOTHER

don't know

13-BIRTHPLACE OF MOTHER (State or Country),

don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Robert Norfolk

(Address),

614 W. Hamburg

15-

JUN 13 1915

ROBERT

KRAUTER

Filed

191

Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Aug 1, 1914 to June 12, 1915.

that I saw her alive on June 12, 1915.

and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

Clinical Diagnosis - Terminal

(Duration) 2 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary)

Carcinoma

(Duration) yrs. mos. ds.

(Signed) M. G. Trueman M. D.

June 12, 1915 (Address) 682 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park

June 15, 1915

20-UNDERTAKER

ADDRESS

Meadow Creek

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *Mary Hospital* ST. *10* WARD) REGISTERED No. C
2-FULL NAME *Frank Shannon* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *1007 Forrest St.* St.; yrs. *23* mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male.* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)
6-DATE OF BIRTH, *November 14, 1891.* (Month) (Day) (Year)
7-AGE, *23* yrs. mos. da. If LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Meter tester.*
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), *Md.*
10-NAME OF FATHER, *David R. Shannon*
11-BIRTHPLACE OF FATHER, (State or Country), *Md.*
12-MAIDEN NAME OF MOTHER, *Mary V. McCloskey*
13-BIRTHPLACE OF MOTHER, (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Mary Shannon (Mother)*
(Address) *1067 Forrest St.*

15- *JUN 13 1915.* ROBERT KRAUTER
Filed..... 191...
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 12, 1915.* (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, au- topsy or inquiry.) and that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Accident - Dislocation of Urinary poisoning.
(Duration) ... yrs. ... mos. *9* da.

CONTRIBUTORY... (Secondary) ... (Duration) ... yrs. ... mos. ... da.
(Signed) *John H. Chambers* M. D.
June 12, 1915. (Address) *18 W. Franklin St.* (Coroner.)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. *9* da. In the State... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Loudon Park* DATE OF BURIAL, *6/15, 1915.*

20-UNDERTAKER, *Mumair Cook* ADDRESS *5028 North*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *1504 McHenry* ST.; *19* WARD)2-FULL NAME *Mary C. Squires*(Residence in Baltimore: No. *1504 McHenry* St.; *65* yrs., *65* mos., *65* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-STATUS
MARRIED
WIDOWED
OR DIVORCED
(Write the word.) *Married*6-DATE OF BIRTH *March 1, 1850*

(Month) (Day) (Year)

7-AGE *65*

If LESS than 1 day,

yrs. mos. ds. hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country), *Baltimore City*10-NAME OF FATHER, *Joseph Squires*11-BIRTHPLACE OF FATHER
(State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *undivided*13-BIRTHPLACE OF MOTHER
(State or Country), *Balto. City*

14- I ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alonso Squires*(Address) *1504 McHenry*

15-

JUN 13 1915

ROBERT KRAUTER

Filed *191* *Bureau*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *June 11, 1915*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 11, 1915*, to *June 11, 1915*that I saw her alive on *June 11, 1915*and that death occurred, on the date stated above, at *8 p.m.*

The CAUSE OF DEATH* was as follows:

Bright's Disease(Duration) *2* yrs. *2* mos. *65* ds.CONTRIBUTORY
(Secondary)(Duration) *2* yrs. *2* mos. *65* ds.(Signed) *Joseph E. Squires* M. D.*June 11, 1915* (Address) *1504 McHenry*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *65* yrs. *65* mos. *65* ds. In the State *65* yrs. *65* mos. *65* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *West Claret*DATE OF BURIAL, *6/14, 1915*20-UNDERTAKER *Mexican Cook*ADDRESS *502 E. 11th*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 N. Washington ST.; 6 WARD)

2-FULL NAME

Residence in Baltimore: No. 220 N. WashingtonSt.; 71 yrs., 4 mos. 2 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Feb 9, 1844
(Month) (Day) (Year)

7-AGE,

71 yrs., 4 mos., 2 ds.IF LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Butcher
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

Geo. W. Trice11-BIRTHPLACE OF FATHER
(State or Country),Md.

12-MAIDEN NAME OF MOTHER

Sarah Reddish13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha A. Trice(Address) 220 N. Washington

15-

Filed

JUN 13 1915ROBERT E. KRAETZCorial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I attended deceased from April 3 1915, to June 11 1915, that I saw him alive on June 11 1915, and that death occurred, on the date stated above, at 8:00 am.

The CAUSE OF DEATH* was as follows:

Chronic disease of heart
with atherosclerosisCONTRIBUTORY (Secondary) Coronary artery disease
(Duration) 2 yrs., 4 mos., 2 ds.(Signed) Edward J. Keen M. D.
6/12, 1915 (Address) 413 N. Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore County

DATE OF BURIAL,

June 13, 1915

20-UNDERTAKER

Zinkler Zinkler

ADDRESS

1739 E. Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86008

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86008

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 4037 Calhoun

ST. 19 WARD)

2-FULL NAME

Margaret Emily Bancroft

(Residence in Baltimore: No. 4037 Calhoun

St. 19 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-STATUS MARRIED (Write the word)

6-DATE OF BIRTH Dec 13th, 1840 (Month) (Day) (Year)

7-AGE 74 yrs. 5 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Accomack Co Va

10-NAME OF FATHER John Walker

11-BIRTHPLACE OF FATHER (State or country) Va

12-MAIDEN NAME OF MOTHER Mary Bellam

13-BIRTHPLACE OF MOTHER (State or country) Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss L. Bancroft

(Address)

4037 Calhoun

15

JUN 13 1915

ROBERT . KRAUTER,

Sanitary Permit Officer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 12th, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1915, to June 9th, 1915, that I saw h & alive on June 9th, 1915, and that death occurred, on the date stated above, at 1:00 a. m. The CAUSE OF DEATH was as follows:

Dilatation of Heart

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) J. A. Lacy M. D.

June 13, 1915 (Address) 1435 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Loyton Park

DATE OF BURIAL

June 15th, 1915

20-UNDERTAKER

Rehman & Co

ADDRESS

1723 N. E. Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

C86009

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86009

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 116 Harlem Ave

ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susanna A. Mitten

(Residence in Baltimore: No. 116 Harlem Ave Str. 16 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX Female 4-COLOR OR RACE white 5-STATUS Widowed 6-DATE OF BIRTH Sept 26, 1836 (Month) (Day) (Year)

10-DATE OF DEATH June 12, 1915 (Month) (Day) (Year)

7-AGE 78 yrs. 8 mos. 14 ds. If LESS than 1 day, hrs. or min.?

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1915, to June 12, 1915, that I saw her alive on June 12, 1915, and that death occurred, on the date stated above, at 6:40 m. The CAUSE OF DEATH* was as follows: Heart Disease

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

(Duration) yrs. mos. ds. Contributory (SECONDARY) Advanced Age (Duration) yrs. mos. ds. (Signed) John C. Cunningham, M. D. June 12, 1915 (Address) 1825 Boston St.

9-BIRTHPLACE (State or country) Carroll Co. Md.

10-NAME OF FATHER Jacob H. Mitten

11-BIRTHPLACE OF FATHER (State or country) Md.

12-MAIDEN NAME OF MOTHER Susanna Lippy

13-BIRTHPLACE OF MOTHER (State or country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. C. Mitten (Address) 116 Harlem Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

15 JUN 13 1915 ROBERT KRAUTER, Filed 1915

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Westminster Carroll Co. Md. June 13, 1915 20-UNDERTAKER Lortum & Gote 1723 W. 1st Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 86010
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.; *14* WARD)

2-FULL NAME

Anna Mik

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs., *2* mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single
(Write the word.)

6-DATE OF BIRTH,

Nov. 25, 1914
(Month) (Day) (Year)

7-AGE,

6 mos. 17 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15- JUN 13 1915

ROBERT

KRAUTH

Filed..... 191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 1st* 1915, to *June 11th* 1915, that I saw her alive on *June 11th* 1915, and that death occurred, on the date stated above, at *200d.m.* The CAUSE OF DEATH* was as follows:*Congenital Hydrocephalus*(Duration)..... yrs. *1* mos. ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *Clarence G. Hall* M. D.*June 12, 1915.* (Address) *1617 E. Mount Airy*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. *14* ds. In the State yrs. *5* mos. *17* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Calver Hall *June 14, 1915*

20-UNDERTAKER

ADDRESS

Martin F. Fyfe *606 Lafayette Ave*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy* ST.; *14* WARD)

2-FULL NAME

Richard Paul(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; *5* yrs., *5* mos. *20* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Dec. *19th*, *1914*.
(Month) (Day) (Year)

7-AGE,

5 yrs., *5* mos., *20* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUN 13 1915

Filed

ROBERT KRAUTER
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 10th, *1915*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 4th *1915*, to *June 10th* *1915*,that I saw him alive on *June 10th* *1915*,and that death occurred, on the date stated above, at *2:00 P. M.*

The CAUSE OF DEATH* was as follows:

Broncho pneumonia(Duration) *4* yrs., *5* mos., *20* ds.

CONTRIBUTORY (Secondary)

(Duration) *1* mos., *20* ds.(Signed) *Clarence G. Hall* M. D.*June 10th*, *1915*. (Address) *617 E. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *5* yrs., *5* mos., *20* ds. In the State *5* yrs., *5* mos., *20* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral**June 13, 1915*

20-UNDERTAKER

ADDRESS

M. Fahy & Sons

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86012 HEALTH DEPARTMENT—CITY OF BALTIMORE C86012
79
PLACE OF DEATH Hebrew Hospital
CITY OF BALTIMORE: (No. 1232 McElderry St.: 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)
3-FULL NAME Belle Hyman
(Residence in Baltimore: No. 1232 McElderry St.: 4 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

1-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow
6-DATE OF BIRTH Unknown, 1 (Month) (Day) (Year)
7-AGE 65 yrs. — mos. — ds. or min. ? If LESS than 1 day, hrs., min. ?
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housework
9-BIRTHPLACE (State or country) Russia
PARENTS
10-NAME OF FATHER Sam Cohen
11-BIRTHPLACE OF FATHER (State or country) Russia
12-MAIDEN NAME OF MOTHER Bailey Cohen
13-BIRTHPLACE OF MOTHER (State or country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

FILED

JUN 13 1915

ROBERT KRAUTH

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 13, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 7, 1915, to June 13, 1915, that I saw her alive on June 13, 1915, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Resection

Contributory (SECONDARY) my cardiac degeneration (Duration) yrs. — mos. — ds. 2
M. B. Lewis (Signed) M. B. Lewis M. D. 6/13/1915 (Address) Hebrew Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. — mos. — ds. 6 In the State yrs. — mos. — ds.

Where was disease contracted, If not at place of death? 1232 McElderry St.

Former or usual residence 1232 McElderry St.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Hospital

June 13, 1915

20-UNDERTAKER

ADDRESS

L. G. Hinson & Co.

1107 E

Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86013

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86013

CERTIFICATE OF DEATH.

x 28

PLACE OF DEATH

CITY OF BALTIMORE (No. *Baltimore City Jail* ST. *10* WARD)

FULL NAME

William Jones
(Residence in Baltimore: No. *Care Springs, Georgia* St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH *Unknown* 1894
(Month) (Day) (Year)
7-AGE, *21* yrs. *—* mos. *—* ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Galvener*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Unknown*
10-NAME OF FATHER, *Unknown*
11-BIRTHPLACE OF FATHER, (State or Country), *Unknown*
12-MAIDEN NAME OF MOTHER, *Unknown*
13-BIRTHPLACE OF MOTHER, (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Jail Records*
(Address)

15- *ROBERT KRAUTER*
Filed *JUN 13 1915* *Bureau of Vital Statistics*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 11, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy, or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Thos. H. Chambers* M. D.

June 11, 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *7* mos. ds. In the *Unknown* State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Unknown

Former or usual residence *Care Springs, Ga.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Sacred Heart Church June 14 1915

20-UNDERTAKER, ADDRESS

Chas. P. Brown & Son 118 W. North Royal Ave.

Spec. — 8-24-14 — M. & T. — 2000 Rks.

C86014

HEALTH DEPARTMENT—CITY OF BALTIMORE

425 Courtland St.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH #475 Courtland St. 4

CITY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME Peter Lohmann

Residence in Baltimore: No. 475 + Courtland St. yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, 52 yrs. - mos. - ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Laborer (b) General nature of industry, business, or establishment in which employed (or employer) Street Sweeping Dept.

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Mrs. Louis Lohmann (Address) 2042 C. Federal St.

15- JUN 13 1915 Filed... 101... ROBERT K. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25, 1915, to June 12, 1915, that I saw him alive on June 11, 1915, and that death occurred, on the date stated above, at 11:22 a.m. The CAUSE OF DEATH* was as follows: Typhoid fever (Duration) ... yrs. ... mos. ... ds. CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds. (Signed) ... (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds. Where was disease contracted, if not at place of death? Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, June 14, 1915 ADDRESS, 1003 W. Baltimore St.

20-UNDERTAKER, Joe B. Cook

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH.

OF BALTIMORE (No. *St Josephs Hosp*)

ST. *9* WARD)

2-FULL NAME *Daniel Sperson*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. *317 S 6th St Highlandtown Md* St. yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*
(Write the word.)

6-DATE OF BIRTH, *June 17, 1913*
(Month) (Day) (Year)

7-AGE, *1* yrs. *11* mos. *25* ds. If LESS than 1 day,hrs. ormin.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Child*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Md*

10-NAME OF FATHER, *Antoni Sperson*

11-BIRTHPLACE OF FATHER (State or Country), *Italy*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Antoni Sperson*

(Address) *317 S 6th St*

15- *JUN 14 1915* *HARRY O. ALBERTS,*
Filed..... 19*Serial Permits Clerk.*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 12, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* (Inquest, au- topy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental burns 2nd degree over arms legs and body, caused by falling in tub of boiling water.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) *Oliver J. Russell* M. D. (Coroner.)
June 13, 1915 (Address) *423 N. Parkway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death? *317 S 6th Highlandtown Md*
Former or usual residence *317 S 6th*

19-PLACE OF BURIAL OR REMOVAL, *St Vincents Cem* DATE OF BURIAL, *June 14 1915*

20-UNDERTAKER *J. Henrich & Co* ADDRESS *2008 Adams*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86016

CERTIFICATE OF DEATH

144 C86016
REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 946 S. Eutaw ST. 21 WARD)

2-FULL NAME Viola Nicholson

Residence in Baltimore: No. 946 S. Eutaw St.; 1 yrs. 2 mos. - ds.)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and RM out No. 11.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Baby

6-DATE OF BIRTH

Apr. 13-

1914

(Month)

(Day)

(Year)

7-AGE

One yrs. 2 mos. - ds. or min?

If LESS than

1 day,

hrs.,

min?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Baby

9-BIRTHPLACE
(State or country)

Balto. City

10-NAME OF FATHER

Edw. Nicholson

11-BIRTHPLACE OF FATHER
(State or country)

D. C. Co., Md.

12-MAIDEN NAME OF MOTHER

Rosie Greene

13-BIRTHPLACE OF MOTHER
(State or country)

D. C. Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edw. Nicholson

(Address)

946 S. Eutaw St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 13th 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 12, 1915 to June 13th 1915,
that I saw her alive on June 12 1915,
and that death occurred, on the date stated above, at 12:45 A.M.

The CAUSE OF DEATH* was as follows:

Abscess of the Leg. (Tibial)
(Duration) about 14 mos. - ds.

Contributory
(SECONDARY)

Embolic Pneumonia
(Duration) about 5 or 6 mos. - ds.

(Signed)

Edw. Nicholson M. D.
June 13, 1915 [Address] 333 P. Gilman St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 1 yrs. 2 mos. - ds. In the State 1 yrs. 2 mos. - ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Auburn June 14 - 1915

20-UNDERTAKER

ADDRESS

L. W. Brown 108 W. Montg. St.

15-

JUN 14 1915

HARRY O. ARISTO,

Serial Form 10 Olor.

REGISTRAR

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86017

CERTIFICATE OF DEATH

103

C86017

1. PLACE OF DEATH

2. OF BALTIMORE (No.)

3. FULL NAME

Residence in Baltimore: No.

ST.

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 27 yrs. 4 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6. DATE OF BIRTH

7. AGE

IF LESS than

1 day, hrs.

or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

JUN 14 1915

HARRY O. ANDREWS,

Registrar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY. That I attended deceased from

May 12, 1915, to June 11, 1915.

that I saw him alive on June 11, 1915.

and that death occurred, on the date stated above, at 4:00 m.

The CAUSE OF DEATH* was as follows:

Gastritis

(Duration)

YES

NO

ds

Contributory
(SECONDARY)

(Duration)

YES

NO

ds

(Signed)

Address 717 Carroll St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Int. Auburn St

June 15, 1915

20. UNDERTAKER

ADDRESS

L. H. Brownson

18 W. Mount St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86018

N CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word.)

Single

6-DATE OF BIRTH

June 1, 1915

(Month)

(Day)

(Year)

7-AGE,

12 ds.

(LESS than 1 day,

hrs. or min.?)

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Poland Patterson

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Edna M. Namora

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edna Patterson

(Address)

1007 N. Wolfe St

15-

JUN 14 1915

HARRY O. ANDREWS,

Filed Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 9th 1915, to June 11, 1915

that I saw her alive on June 11, 1915,

and that death occurred, on the date stated above, at 1130 P.M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) 5 yrs. 1 mo. 12 ds.

CONTRIBUTORY Malformation of Heart

(Secondary)

(Signed) Harry O. Andrews, M. D.

1025 N. Wolfe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Oak Hill

June 19, 1915

20-UNDERTAKER

Eugene Crachson

ADDRESS

1904 Westland

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

X This is the true and correct statement of the death of the deceased as given by the informant.

WRITE IN INK WITH U.S. AGING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86019

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86019

CERTIFICATE OF DEATH

x 74

1 PLACE OF DEATH

REGISTERED NO. C

CITY BALTIMORE: (No. *Johns Hopkins Hosp. 7*)

WARD

2 FULL NAME *Dennis Uhl*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM not No. 18.)

(Residence in Baltimore: No. *1115 Broadway Logansport Ind.* St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *white* 5-SINGLE *single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Oct 21, 1899*
(Month) (Day) (Year)

7-AGE *15 yrs 7 mos 23 ds* If LESS than 1 day, hrs. or min.?

8-OCCUPATION *school-boy*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Ind.*

10-NAME OF FATHER *Walter Uhl*

11-BIRTHPLACE OF FATHER (State or country) *Ind.*

12-MAIDEN NAME OF MOTHER *Barrie Rutter*

13-BIRTHPLACE OF MOTHER (State or country) *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. B. Curry*

(Address) *J. H. Hoef*

JUN 14 1915
FILE 191

HARRY O. ANDREWS
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 13, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr. 12, 1915* to *June 13, 1915*, that I saw him alive on *June 13, 1915* and that death occurred, on the date stated above, at *3:25 p.m.*

The CAUSE OF DEATH* was as follows:
Brain Tumor (not tuberculous)

(Duration) *3 yrs 7 mos - ds.*

Contributory (SECONDARY) *Apoplexy*

(Duration) *3 yrs - mos. - ds.*

(Signed) *George R. Dunn* M. D.
June 13, 1915 [Address] *J. H. Hoef*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds. *62 yrs 62 mos 62 ds.*

Where was disease contracted, If not at place of death?

Former or usual residence *Logansport Ind.*

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Logansport Ind. *June 14, 1915*

20-UNDERTAKER ADDRESS

Willard C. Kuller *221 N. Breeding*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

710 S. Bethel

2-FULL NAME

Frances Broka

(Residence in Baltimore: No.

710 S. Bethel

REGISTERED NO. C

ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 3 mos. 8 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

March 5, 1915
(Month) (Day) (Year)

7-AGE,

yrs. 3 mos. 8 da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Michael Broka

11-BIRTHPLACE OF FATHER
(State or Country),

Austria Poland

12-MAIDEN NAME OF MOTHER

Katherine K. Nezek

13-BIRTHPLACE OF MOTHER
(State or Country),

Austria Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Michael Broka

(Address)

710 S. Bethel St.

15-

JUN 14 1915

HARRY O. ANDREWS,

Baltimore Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 13, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 12 1915, to June 13 1915, that I saw her alive on June 13 1915, and that death occurred, on the date stated above, at 12¹⁵ m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(Duration) yrs. mos. 7 da.

CONTRIBUTORY
(Secondary)

Convulsions

(Duration) yrs. mos. 1 da.

(Signed) John H. Rehberger M. D.

June 13, 1915 (Address) 1709 Allen Ave. N.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

June 14, 1915

20-UNDERTAKER

M. F. Sadowski

ADDRESS

705 S. Ann

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86021

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 870. S Dallas Str., ST. 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Szczepan Jegielski,

(Residence in Baltimore: No. 870. S Dallas Str., St.; 18 yrs., 8 mos., 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mala 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, Oct 4, 1896 (Month) (Day) (Year)

7-AGE, 18 yrs., 8 mos., 8 ds. It LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None (b) General nature of industry, business, or establishment in which employed (or employer), Laborer

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.	10-NAME OF FATHER,	Frank Jegielski
	11-BIRTHPLACE OF FATHER (State or Country),	Germany
	12-MAIDEN NAME OF MOTHER	Jadwiga Grzechowiak
	13-BIRTHPLACE OF MOTHER (State or Country),	Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. Frank Jegielski, (Informant) (Address) 870. S Dallas Str.,

15- JUN 14 1915 HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 5, 1915, to June 12, 1915, that I saw him alive on June 11, 1915, and that death occurred, on the date stated above, at 12:15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis (Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) asthma (Duration) yrs. 1 mos. ds.

(Signed) Thos. A. Mitchell, M. D. June 12, 1915. (Address) 105 Madison Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary DATE OF BURIAL, June 15, 1915

20-UNDERTAKER, William Fialkowski, ADDRESS, 1618 Eastern Ave,

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86022

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *845 South Bond St.* ST.; *109* WARD)FULL NAME *Ignacy Sagnora*(Residence in Baltimore: No. *845 South Bond St.* St.; *109* yrs., *1* mos., *1* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE,

White
Russian Pol.

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widower

6-DATE OF BIRTH,

Sept. 1, 1891
(Month) (Day) (Year)

7-AGE,

About 52
yrs. mos. ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9-BIRTHPLACE,

(State or Country),

Russia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joe Sassinski
845 South Bond St.
(Address)

15-

JUN 14 1915 *ROCKHILL* *GRANT*
Filed *1915* *Serial* *Permit* *Clark*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

June 12, 1915, to *June 12, 1915*,that I saw him alive on *June 12, 1915*,and that death occurred, on the date stated above, at *6:40 PM*.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
40 yrs
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Cardiac Dilatation
(Duration) yrs. mos. ds.(Signed) *William B. Blanchard*, M. D.*June 12, 1915* (Address) *Ind. Gen. Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *845 South Bond St.*Former or usual residence *845 South Bond St.*

PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Patterson H. J. *June 15, 1915*

20-UNDERTAKER

ADDRESS

William L. Gifford *1618 Eastern Ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86023

CERTIFICATE OF DEATH.

64

C86023

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *931 N. Mount* ST.; *16* WARD)

2. FULL NAME

(Residence in Baltimore: No. *931 N. Mount* St.; *64* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX.

Female

4. COLOR OR RACE,

White

5. MARRIED,

WIDOWED, divorced
(Write the word.) **

6. DATE OF BIRTH,

(Month) (Day) (Year) *1*

7. AGE,

64

If LESS than 1 day.

...hrs. or...min.

8. OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*9. BIRTHPLACE,
(State or Country),*Md*

10. NAME OF FATHER,

*Stephen Cransblitt*11. BIRTHPLACE OF FATHER
(State or Country),*Md*

12. MAIDEN NAME OF MOTHER

*Sophia Doyle*13. BIRTHPLACE OF MOTHER
(State or Country),*Pa*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Hamilton*(Address) *931 N. Mount St*

JUN 14 1915

Filed.....

ROBERT J. KROGER
JOYCE J. KROGER
Registral

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH,

June 12, 1915
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *June 11 1915* to *June 12 1915*, that I saw her alive on *June 11 1915*, and that death occurred, on the date stated above, at *1 a. m.*, The CAUSE OF DEATH* was as follows:

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis(Duration) *2* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Central Hemorrhage*(Duration) *2* yrs. mos. ds.(Signed) *T. N. ...*

M. D.

101... (Address) *317 N. Carroll St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL,

Baltimore Am.

DATE OF BURIAL,

June 14, 1915

20. UNDERTAKER

Mrs. A. Rohde Am.

ADDRESS

730 Pa Am

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

169

C86024

1-PLACE OF DEATH *Franklin Sq. Hospt.*
CITY OF BALTIMORE (No. *15* ST. *15* WARD)
2-FULL NAME *Joseph F. Hefner*
(Residence in Baltimore: No. *1318 N. Fremont*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *8* yrs., *9* mos. *29* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)
6-DATE OF BIRTH, *Aug. 13th, 1906*
(Month) (Day) (Year)
7-AGE, *8* yrs., *9* mos., *29* ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *School boy*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Balto Md.*

10-NAME OF FATHER, *Andrew Hefner*
11-BIRTHPLACE OF FATHER (State or Country), *Md*

12-MAIDEN NAME OF MOTHER *Catherine Smith*

13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Andrew Hefner*
(Address) *1318 N. Fremont*

15-
Filed *JUN 14 1915* HARRY O. ADAMS,
Regist. *1318 N. Fremont*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 12th, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental Drowning.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Sam'l W. Minter*
(Signed) *June 12th, 1915* (Address) *2302 Madison Ave*
(Coroner) M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. *1/2* ds. In the *8* yrs. mos. ds.
Where was disease contracted, if not at place of death? *Swyn Hall, Edmondson Ave*
Former or usual residence *1318 N. Fremont Ave*

19-PLACE OF BURIAL OR REMOVAL, *New Cathedral Cemetery* DATE OF BURIAL, *June 15, 1915*

20-UNDERTAKER, *Mrs A Rohde Son* ADDRESS *930 Palm*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86025

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86025

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *944 N. Broadway*)

2-FULL NAME *Henry Vocker*

(Residence in Baltimore: No. *944 N. Broadway*)

REGISTERED NO. C.....

WARD).....

(If death occurred in a hospital or institution, give its NAME instead of street and number and file No. 18.)

St. *56* yrs. *2* mos. *9* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOW

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

April 2nd 1859

7-AGE

56 yrs. *2* mos. *9* ds. or min. *9* If LESS than 1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work *Retired*
(b) General nature of industry, business, or establishment in which employed (or employed) *Shoemaker*

9-BIRTHPLACE (State or country)

Balts. Md.

PARENTS

10-NAME OF FATHER

Not known

11-BIRTHPLACE OF FATHER (State or country)

Germany

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Mrs. May W. Vocker

(Address) *944 N. Broadway*

15-

JUN 14 1915.

Filed *191*

BARRY O. ARDREY,

Serial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 11th 1915.

HEREBY CERTIFY, That I attended deceased from *June 3rd 1915* to *June 11th 1915*

that I saw him alive on *June 11th 1915* and that death occurred, on the date stated above, at *8:30 p.m.*

The CAUSE OF DEATH* was as follows:

Acute Lobar

Pneumonia
Contributory
Exhaustion
Heart Failure
St. Mary's Hospital
June 11th 1915 (Address) *1031 N. Caroline St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, If not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

Trinity

DATE OF BURIAL

June 14 1915

20-UNDERTAKER

H. Sanders & Sons

ADDRESS

1710 E. 1st St.

C86026

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86026

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2909 Brighton ST., 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. 2909 Brighton

St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

March 27, 1847
(Month) (Day) (Year)

7-AGE,

68 yrs. 2 mos. 16 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country).

Kentucky

PARENTS.

10-NAME OF FATHER,

Henry Young

11-BIRTHPLACE OF FATHER

(State or Country).

N. Carolina

12-MAIDEN NAME OF MOTHER

Mary Finn

13-BIRTHPLACE OF MOTHER

(State or Country).

Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. I. Sabella Young

(Address) 2909 Brighton St.

15 JUN 14 1915.

Filed..... 191... Special Permit... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 15, 1914, to June 12, 1915,

that I saw him alive on June 12, 1915,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 11 mos. 6 ds.

CONTRIBUTORY (Secondary)

Coronary Arteriosclerosis

(Duration) yrs. 2 mos. 6 ds.

(Signed)

Herbert E. Jeph

M. D.

June 13, 1915. (Address) 3050 N. Union

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

Cale Lawn Cemetery

June 15, 1915.

20-UNDERTAKER

ADDRESS

Henry Lutz

1007 N. Bond St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86027

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86027

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1725 Borsuch Ave ST. 9 WARD)

FULL NAME Joseph F. Mustland

(Residence in Baltimore: No. 1725 Harbor Ave

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 36 yrs., mos., ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Hosiery Shop (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Ind

10-NAME OF FATHER, Henry Mustland

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Caroline Truelich

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viith Mustland

(Address) 2000 Harbor Ave

15-

JUN 14 1915

HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, June 10, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed) Edison Russell M. D. (Coroner.)

June 11, 1915 (Address) 423 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Baltimore Cemetery June 14, 1915

20-UNDERTAKER, ADDRESS

George J. Reuth 1735 Harbor Ave

C86028

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86028

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 E. North St.; 9 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1136 E. North St.; 9 yrs. 2 mos. 24 da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH

June 14, 1847
(Month) (Day) (Year)

7-AGE

67 yrs. 11 mos. 24 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Nurse9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

June 14 1915

HARRY O. ARDRETT,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH

June 13, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 9 1915 to June 13 1915, that I saw him alive on June 13 1915, and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH was as follows:

Bright's DiseaseCONTRIBUTORY
(Secondary)

(Signed)

June 14, 1915 (Address) 1531 E. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 9 yrs. 2 mos. 24 ds. In the State 9 yrs. 2 mos. 24 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86030

C86030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1405 E Eager* ST.;

REGISTERED NO. C

FULL NAME *Ferdinand Mandaga*(Residence in Baltimore: No. *1405 E Eager St*St.; *25* yrs., .. mos. .. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

White

5-STATUS

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word)

Married

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

infant 84

yrs. .. mos. .. ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

not known

11-BIRTHPLACE OF FATHER

(State or Country),

not known

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER

(State or Country),

not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Christina Mandaga*(Address) *1405 E Eager St*

15-

*JUN 14 1915**HARRY O. ADKINS,*

Filed

191

121 Permit 0107

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 13, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 17, 1915* to *June 13, 1915*, that I saw him alive on *June 13, 1915*, and that death occurred, on the date stated above, at *5:30* p. m.

The CAUSE OF DEATH was as follows:

Enlarged Prostate
Cystitis
Acute Bright's Disease

(Duration) .. yrs. .. mos. .. ds.

CONTRIBUTORY (Secondary)

(Duration) .. yrs. .. mos. .. ds.

(Signed) *Dr. J. L. Smith* M. D.*June 14, 1915* (Address) *1405 E Eager St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .. yrs. .. mos. .. ds. In the .. State .. yrs. .. mos. .. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Western Cemetery**June 16, 1915*

20-UNDERTAKER

ADDRESS

*Shirley North Sun**1301 E Eager St*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.....

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hosp 8*) WARD
2. FULL NAME *George Brooks*
Residence in Baltimore: No. *2117 Mura St* St.; *1* yrs. *2* mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and its out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *white* 5-SINGLE *single*
MARRIED WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH *April 14 1914*
(Month) (Day) (Year)
7-AGE *1* yrs. *2* mos. — ds. or min.?
8-OCCUPATION (a) Trade, profession or particular kind of work *Infant*
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE (State or country) *Md (Balto City)*
10-NAME OF FATHER *George Brooks*
11-BIRTHPLACE OF FATHER (State or country) *City*
12-MAIDEN NAME OF MOTHER *Margaret A Constantine*
13-BIRTHPLACE OF MOTHER (State or country) *City*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Arberry*
(Address) *J. H. Hoep*

JUN 14 1915
Filed 191

HARRY O. ANDREWS,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 13 1915*
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from *June 12 1915*, to *June 13 1915*, that I saw him alive on *June 13 1915*, and that death occurred, on the date stated above, at *4:40 p.m.*
The CAUSE OF DEATH* was as follows:

Auditis

(Duration) yrs. mos. 3 ds.
Contributory (SECONDARY) *Typhoid colitis*
(Duration) yrs. mos. 7 ds.
(Signed) *Alvin S. Rothkopf* M. D.
June 13 1915 [Address] *2117 Mura St*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *9 1/2* In the *1* yrs. *2* mos. — ds.
Where was disease contracted, if not at place of death?
Former or usual residence *2117 Mura St*

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Holy Redeemer Church *June 14 1915*

20-UNDERTAKER ADDRESS
Henry Harkins *1301 E Eager*

C86032

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 Courtland St. 4 WARD)

FULL NAME

Susannah Mitchell

Residence in Baltimore: No.

215 Courtland St.

St.; — yrs., — mos., — ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
widow

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

56 yrs., — mos., — ds.

If LESS than 1 day,

— hrs. or — min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE, (State or Country).

Maryland

PARENTS.

10-NAME OF FATHER,

Peter Butcher

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John A. Green

(Address)

215 Courtland St.

15-

JUN 14 1915.

Filed

191

GARRY O. ADAMS,

Serial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 13, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 28 1915, to June 13 1915,

that I saw him alive on June 12 1915,

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Bright's Disease
(Duration) — yrs., 4 mos., 16 ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs., — mos., — ds.

(Signed) Wm. A. Green M. D.

June 14 1915. (Address) 215 Courtland St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

West end

DATE OF BURIAL,

June 15, 1915

20-UNDERTAKER

John A. Green 1221 Union

ADDRESS

C86033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

C86033

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *242 Oak St.*)ST.; *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2—FULL NAME

(Residence in Baltimore: No. *3424 Oak St.*)St.; *30* yrs., *12* mon., *14* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3—SEX

Male

4—COLOR OR RACE

*White*5—SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6—DATE OF BIRTH

March 17, 1860
(Month) (Day) (Year)

7—AGE

55 yrs., *2* mos., *28* ds.If LESS than 1 day,
....hrs. or....min.?

8—OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Ice Maker*

9—BIRTHPLACE, (State or Country),

Italy

10—NAME OF FATHER

Paul Romano

11—BIRTHPLACE OF FATHER (State or Country),

Italy

12—MAIDEN NAME OF MOTHER

Ann Romano

13—BIRTHPLACE OF MOTHER (State or Country),

Italy

14—THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Pauline Romano*(Address) *1105 Cassin St.*

15—

June 14 1915

191...

HARRY O. ARKES

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16—DATE OF DEATH

June 14, 1915
(Month) (Day) (Year)17— I HEREBY CERTIFY, That I attended deceased from *June 1, 1915*, to *June 14, 1915*, that I saw him alive on *June 13, 1915*, and that death occurred, on the date stated above, at *1 9* m. The CAUSE OF DEATH* was as follows:*Tuberculosis Pulmonis*
(Duration)....yrs. *3* mos.ds.

CONTRIBUTORY (Secondary)

(Signed) *Jacob Fisher* M. D.
June 14, 1915 (Address) *1924 E. 1st Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18—LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.mos.ds. In the State....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19—PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

....., 191...

20—UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1633 Disquith ST.; 9 WARD) REGISTERED NO. C
2-FULL NAME Frank Frietsch
(Residence in Baltimore: No. 1633 Disquith St.; 49 yrs., 6 mos., 30 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, Married, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, November 13th, 1865
(Month) (Day) (Year)
7-AGE, 49 yrs., 6 mos., 30 ds. If LESS than 1 day,hrs. or....min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, Baltimore Md
Joseph Frietsch
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER Catherine Wendt
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Frietsch
(Address) 1633 Disquith st

15-
Filed JUN 14 1915 HARRY O. ARNOLD, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7mch, 1915, to June 11, 1915, that I saw him alive on June 11, 1915, and that death occurred, on the date stated above, at 3:50a m. The CAUSE OF DEATH* was as follows:

Endocarditis
(Duration) 9 yrs., 1 mos., 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Signed) J. H. Robinson M. D.
June 11, 1915 (Address) 726 E. Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 49 yrs., 6 mos., 30 ds. In the State 49 yrs., 6 mos., 30 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, June 15th, 1915.

20-UNDERTAKER George Schilling & Sons ADDRESS 1126 E. Monument

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86036

CERTIFICATE OF DEATH.

C86036

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1448 Usqueith* ST.: *9* WARD)2-FULL NAME *Capt. John Fehring*(Residence in Baltimore: No. *1448 Usqueith* St.: *50* yrs., mos. ds.)

79 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widowed*

6-DATE OF BIRTH,

April 24th, 1836
(Month) (Day) (Year)

7-AGE,

79 yrs. 1 mos. 20 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Retired Sea Captain*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Isaac A. Hahn*(Address) *1448 Usqueith St.*

15-

Filed *JUN 14 1915* Serial Permit *0107*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 13, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 12 1915 to June 13 1915*that I saw him alive on *June 12 1915*and that death occurred, on the date stated above, at *125 a.m.*

The CAUSE OF DEATH* was as follows:

Ordinary of Lung
(Duration) *24 hrs.*

CONTRIBUTORY (Secondary)

Coronary Infection
(Duration) *undetermined*
(Signed) *E. H. Haywood* M. D.
6/13, 1915 (Address) *P. O. Box 125, E. Preston*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

June 13th, 1915

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Monument St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86037

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.; *18* WARD)

2-FULL NAME

(Residence in Baltimore: No. *868 Lemon St.* St.; *31* yrs., *10* mos. *4* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word.)

6-DATE OF BIRTH

7-AGE

IF LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE

(State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

FILED

JUN 14 1915

HARRY O. A. L. E. S.

191..Burial..Parish..Glory..

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

June 7 1915, to *June 13* 1915that I saw her alive on *June 13* 1915and that death occurred, on the date stated above, at *4:20 P.* M.

The CAUSE OF DEATH* was as follows:

*General Arterio Sclerosis**Coronary Arterio Sclerosis**Chronic Myocarditis**Chronic Nephritis**Chronic Bronchitis**Chronic Emphysema**Chronic Catarrh of the Stomach**Chronic Catarrh of the Duodenum**Chronic Catarrh of the Small Intestine**Chronic Catarrh of the Large Intestine**Chronic Catarrh of the Rectum**Chronic Catarrh of the Uterus**Chronic Catarrh of the Vagina**Chronic Catarrh of the Cervix**Chronic Catarrh of the Ovaries**Chronic Catarrh of the Fallopian Tubes**Chronic Catarrh of the Uterine Tubes**Chronic Catarrh of the Uterine Tubes**Chronic Catarrh of the Uterine Tubes**Chronic Catarrh of the Uterine Tubes**Chronic Catarrh of the Uterine Tubes**Chronic Catarrh of the Uterine Tubes**Chronic Catarrh of the Uterine Tubes**Chronic Catarrh of the Uterine Tubes**Chronic Catarrh of the Uterine Tubes**Chronic Catarrh of the Uterine Tubes**Chronic Catarrh of the Uterine Tubes**Chronic Catarrh of the Uterine Tubes**Chronic Catarrh of the Uterine Tubes*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86038

C86038

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *206 E Fort Ave* ST.; *20* WARD)

2-FULL NAME

(Residence in Baltimore: No. *206 E Fort Ave* St.; *1* yrs., *3* mos., *21* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

Feb *21*, 1914
(Month) (Day) (Year)

7-AGE,

1 yrs., *3* mos., *21* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country).*Bald City*

10-NAME OF FATHER,

*Chas Snyder*11-BIRTHPLACE OF FATHER
(State or Country).*Bald*

12-MAIDEN NAME OF MOTHER

*Agnis Holzman*13-BIRTHPLACE OF MOTHER
(State or Country).*Bald*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

Ms Snyder
206 E Fort Ave

15 JUN 14 1915.

Filed....., 191

Serial *10101*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

6 *12*, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

4.28 1915, to *6.12* 1915,that I saw him alive on *6.12* 1915,and that death occurred, on the date stated above, at *2 P* m.

The CAUSE OF DEATH* was as follows:

(Acute Meningitis)
from infection
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)*Chronic Bronchitis*
is deemed
(Duration)..... yrs..... mos..... ds.

(Signed).....

D. J. Livingston M. D.*6.12, 1915* (Address) *102 E Fort Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

June 14, 1915

20-UNDERTAKER

D. J. Livingston

ADDRESS

1422 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)2-FULL NAME *Jane Krause*(Residence in Baltimore: No. *Reisterstown Md.* St.: *Reisterstown Md.* yrs. *4* mos. *6* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*4-COLOR OR RACE. *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widow*
(Write the word.)6-DATE OF BIRTH, *Dec*, *1897*

(Month)

(Day)

(Year)

7-AGE, *18* yrs. *6* mos. *—* ds.If LESS than 1 day, *—* hrs. or *—* min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), *Maryland*10-NAME OF FATHER, *C. Mann*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Virginia Fatten*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jacob Krause*(Address) *Reisterstown Md.*

15-

JUN 14 1915 HARRY O. ANDREWS,
Filed *1915* *Reisterstown Md.* *Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 14*, *1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 10*, *1915*, to *June 14*, *1915*,that I saw her alive on *June 14*, *1915*,and that death occurred, on the date stated above, at *6 A* m.

The CAUSE OF DEATH* was as follows:

Streptococcus Cellulitis
of left arm + Septicemia(Duration) *4* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.(Signed) *Elmer Hewes* M. D.*June 14 1915* (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *4* ds. In the *55* yrs. *6* mos. *—* ds.Where was disease contracted, *—*
if not at place of death?Former or usual residence *Reisterstown Md.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL, *June 16, 1915**Sandey Mount Burial Co*20-UNDERTAKER *Carroll Co Md*ADDRESS *Reisterstown Md**J. H. Eline**Reisterstown Md*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86040

CERTIFICATE OF DEATH

151

C86040

PLACE OF DEATH

CITY OF BALTIMORE (No. 134 N. Chapel

ST. 6 WARD)

2-FULL NAME

Rosie Cheney

(Residence in Baltimore: No. 134 N. Chapel

St. Light mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6-DATE OF BIRTH *June 10, 1915*
(Month) (Day) (Year)

7-AGE *4* yrs. *4* mos. *4* ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Ind (City)

10-NAME OF FATHER

George Cheney

11-BIRTHPLACE OF FATHER (State or country)

Ind.

12-MAIDEN NAME OF MOTHER

Mary Marshall

13-BIRTHPLACE OF MOTHER (State or country)

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Cheney

(Address)

1734 Gough St.

JUN 14 1915

HARRY O. ANDREWS,

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 14, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I attended deceased from *June 10, 1915* to *June 14, 1915* that I saw her alive on *June 13, 1915* and that death occurred, on the date stated above, at *6 A. m.* The CAUSE OF DEATH was as follows:

Exhaustion

Contributory (SECONDARY) *Premature birth*
(Duration) yrs. mos. ds.

(Signed) *Henry H. Weidner* M. D.
June 14, 1915 (Address) *724 W. Fayette St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Cross

DATE OF BURIAL

June 14, 1915

20-UNDERTAKER

Wendell Biffell Stom

ADDRESS

37 S. Ann St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86041

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3503 Pawhatan Ave ST. 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. 3503 Pawhatan Ave St.; 50 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

May 1st, 1860
(Month) (Day) (Year)

7-AGE,

55 yrs., 1 mos., 12 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Commissioner
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

9-BIRTHPLACE, (State or Country),

Somerset Co. Md.

10-NAME OF FATHER,

Manheim Todd

11-BIRTHPLACE OF FATHER (State or Country),

Somerset Co. Md.

12-MAIDEN NAME OF MOTHER

Emily Scott

13-BIRTHPLACE OF MOTHER (State or Country),

Somerset Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith T. Phillips(Address) 3503 Pawhatan Ave

JUN 14 1915

HARRY O. ANDREWS,

Filed 1/14 1915 Serial Permit Clerk's Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Mar 12 1915, to June 12 1915, that I saw him alive on June 12th 1915, and that death occurred, on the date stated above, at 11:35 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) 5 yrs., mos., ds.

CONTRIBUTORY (Secondary)

Cardiac Exhaustion
(Duration) 2 yrs., mos., ds.
(Signed) Arthur H. Phillips M. D.
June 14, 1915 (Address) 2011 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Louisa Park Cem

DATE OF BURIAL,

June 14, 1915

20-UNDERTAKER

Robt Brooks Son & Co Calhoun & Hollins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86042

91 C86042

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp 5* St. *5* WARD)

2-FULL NAME

James Waters

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)

(Residence in Baltimore: No. *1502 Mullikin St* St.; *—* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

Black

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

single

6-DATE OF BIRTH

Apr 25 1915
(Month) (Day) (Year)

7-AGE

1 yrs. *18* mos. *18* ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE
(State or country)

Md.

10-NAME OF FATHER

Howard Waters

11-BIRTHPLACE OF FATHER
(State or country)

Md.

12-MAIDEN NAME OF MOTHER

Annie Collins

13-BIRTHPLACE OF MOTHER
(State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arcler

(Address)

J. H. Hoops

JUN 14 1915

HEALTH U. ANDREWS,
Chief, Permit Clerk.

Filed

1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 12 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 12 1915, to *June 2 1915*,

that I saw him alive on *June 12 1915*

and that death occurred, on the date stated above, at *7:15 p.m.*

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

7 ds.

(Duration) yrs. mos. ds.

(Signed) *Alma S. Rothol* M. D.

June 13 1915 [Address] *1502 Mullikin St*

*State the DISEASE CAUSING DEATH or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *6 1/2* yrs. in the State yrs. *1* mos. *18* ds.

Where was disease contracted, If not at place of death?

Former or usual residence *1502 Mullikin St*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laurel Hill June 15 1915

20-UNDERTAKER

ADDRESS

Roth & Elkholt 500 East St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86043

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Provenance dead Mary Hospital 5* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)
2-FULL NAME *Jennie Smith*
(Residence in Baltimore: No. *28 Painters Court* 34 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
6-DATE OF BIRTH. *Unknown, 1*
(Month) (Day) (Year)
7-AGE. *32* yrs. mos. ds. IT LESS than 1 day, ...hrs. or ...min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Domestic*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *City*

PARENTS.

10-NAME OF FATHER. *Joseph Smith*
11-BIRTHPLACE OF FATHER (State or Country), *City*
12-MAIDEN NAME OF MOTHER *Mary Jones*
13-BIRTHPLACE OF MOTHER (State or Country), *City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph Smith*
(Address) *28 Painters Ct.*

15- JUN 14 1915, HARRY O. ANDREWS, Registrar.
Filed. 191. Burial Permit Oler's

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 11, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said. (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: *acute cardiac dilatation*

(Duration) yrs. mos. ds.
CONTRIBUTORY. *Myocarditis*
(Secondary)

(Duration) yrs. mos. ds.
(Signed) *Wm. H. Chamber* M. D. (Coroner.)
June 14 1915 (Address) *18 N. Franklin*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. In the State. yrs. mos. ds.
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Ashbury* DATE OF BURIAL, *June 14, 1915*

20-UNDERTAKER, *Wm. J. Jackson* ADDRESS *1409 Mulberry St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 Wilmer alley ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME infant of Clara Vanderford(Residence in Baltimore: No. 1235 Wilmer alley St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

Black5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
single

6-DATE OF BIRTH

June 12, 1915
(Month) (Day) (Year)

7-AGE,

— yrs. — mos. — ds.

IF LESS than 1 day,

21 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),Ind

12-MAIDEN NAME OF MOTHER

Clara Brown13-BIRTHPLACE OF MOTHER
(State or Country),Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Freeman(Address) University Hospital

15-

JUN 14 1915

ROBERT KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 13, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 12 1915 to June 13 1915that I saw him alive on June 12 1915,
and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Cathectasis21 hoursCONTRIBUTORY 8 mm. fracture(Duration) 21 hours(Signed) W. H. Freeman M. D......, 191... (Address) Univ. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Peter's CemeteryJune 14, 1915

20-UNDERTAKER

ADDRESS

Alfred J. Freeman1415 Camden

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86045

CERTIFICATE OF DEATH.

151 C86045

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Md. Gen. Hosp.

ST.

19

WARD)

REGISTERED NO. C

2-FULL NAME

Baby Jackson.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

Md. Gen. Hospital

St.;yrs.,mos.,ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

June

9

1915

(Month)

(Day)

(Year)

7-AGE.

.....yrs.,mos.,ds.

If LESS than 1 day,

.....hrs. or.....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

Maryland.

10-NAME OF FATHER.

Norman Jackson

11-BIRTHPLACE OF FATHER

(State or Country).

Maryland

12-MAIDEN NAME OF MOTHER

Grace Rodger

13-BIRTHPLACE OF MOTHER

(State or Country).

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

R. L. Wright

(Address).....

Md. Gen. Hosp.

15-

ROBERT

JOHNS

KRAUTER

Filed JUN 14 1915

Suppl. Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June

9

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 8, 1915, to June 9, 1915,

that I saw her alive on June 9, 1915,

and that death occurred, on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows:

Immaturity

(Duration).....yrs.,mos.,ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.,mos.,ds.

(Signed).....K. B. E. Seegar.....M. D.

6/9, 1915. (Address).....Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.,mos.,ds. In the State.....yrs.,mos.,ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

HOPKINS HOSPITAL

DATE OF BURIAL

JUN 11 1915

20-UNDERTAKER

ADDRESS

FOR ANATOMICAL PURPOSES

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86046

CERTIFICATE OF DEATH

37

C86046

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2455 Dallas)

ST. 3 WARD

3-FULL NAME

Baby Pembrey

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM. out No. 12.)

(Residence in Baltimore: No. 2455 Dallas)

St. _____ yrs. _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

M

4-COLOR OR RACE

D

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

single

6-DATE OF BIRTH

June

10

1915

7-AGE

1

If LESS than

1 day, 1 hr.

_____ yrs. _____ mos. _____ ds. or _____ min?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

9-BIRTHPLACE

(State or country)

Ind

10-NAME OF FATHER

James Pembrey

11-BIRTHPLACE OF FATHER

Ind

12-MAIDEN NAME OF MOTHER

Ella Heaven

13-BIRTHPLACE OF MOTHER

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

10

1915

I HEREBY CERTIFY, That I attended deceased from

June 10, 1915, to June 14, 1915,

that I saw him alive on June 10, 1915,

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity (8 mos.)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY)

Syphilis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. H. H. M. D.

June 11, 1915 [Address] J. H. H.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

JUN 11 1915

Laundromat

FOR ANATOMICAL

ADDRESS

PURPOSES.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86047

CERTIFICATE OF DEATH.

C86047

151

PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 10 WARD)

FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

June 10, 1915
(Month) (Day) (Year)

7-AGE, &

20 months

If LESS than 1 day,

yrs. mos. ds.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Baldwin

10-NAME OF FATHER,

Albert George

11-BIRTHPLACE OF FATHER (State or Country),

D.C.

12-MAIDEN NAME OF MOTHER

Blanche Robinson

13-BIRTHPLACE OF MOTHER (State or Country),

D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 14 1915

ROBERT KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 10, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I saw h. alive on 191

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature Death - 5 1/2 months

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

June 11, 1915 (Address) L. J. Ponce

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

FOR ANATOMICAL PURPOSES

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *Bald City Jail*) ST.: *10* WARD) (If death occurred in a hospital or institution, give its NAME; instead of street and number and all out No. 18.)
2-FULL NAME *Mary Robinson*
(Residence in Baltimore: No. *Bald City Jail* St.: _____ yrs., _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *Col.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, *June 10*, 1915 (Month) (Day) (Year)
7-AGE, _____ yrs., _____ mos., _____ ds. If LESS than 1 day, _____ hrs. or 10 min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9-BIRTHPLACE, (State or Country), *Bald City Jail*

10-NAME OF FATHER, *Albert Jones*
11-BIRTHPLACE OF FATHER (State or Country), *B.C.*
12-MAIDEN NAME OF MOTHER *Blaude Robinson*
13-BIRTHPLACE OF MOTHER (State or Country), *B.C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) _____

(Address) _____

15-

JUN 14 1915

ROBERT KRAUTH
Baltimore Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 10*, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from _____ 191 _____, to _____ 191 _____, that I saw him alive on *June 10* 1915, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: *1 1/2 months Premature Birth - died a few minutes after birth*

(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *Dr. J. M. D.* M. D.
June 11, 1915. (Address) *691 N. My*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

HOPKINS HOSPITAL JUN 11 1915

20-UNDERTAKER

Commissioner Health.

ADDRESS

FOR ANATOMICAL PURPOSES

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 PLACE OF DEATH *Nursery & Childs Hosp.* REGISTERED NO. C.....
 CITY OF BALTIMORE: (No. *Franklin & Schroeder 18* WARD)
 FULL NAME *George Roberts*
 (Residence in Baltimore: No. *Nursery & Childs* St.;yrs.,mos.ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
 6-DATE OF BIRTH, *Feb. 12, 1915*
 (Month) (Day) (Year)
 7-AGE, *3 mos. 28 da.* If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Unknown*
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Unknown*

10-NAME OF FATHER, *Unknown*
 11-BIRTHPLACE OF FATHER (State or Country), *Unknown*
 12-MAIDEN NAME OF MOTHER, *Unknown*
 13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *Nursery & Childs Hosp.*
 (Address).....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 11, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 8, 1915*, to *June 11, 1915*, that I saw him alive on *June 11, 1915*, and that death occurred, on the date stated above, at *12:30 p.m.*

The CAUSE OF DEATH* was as follows:

Alimentary Intoxication
 (Duration).....yrs.....mos.....ds. *3*

CONTRIBUTORY.....
 (Secondary)

(Signed) *Edgar H. Friedman* M. D.
Jan 21, 1915 (Address) *1616 Linden Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *3* mos. *21* ds. In the State yrs.mos.ds.

Where was disease contracted, if not at place of death? *Unknown*

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *JOHNS HOPKINS HOSPITAL* DATE OF BURIAL, *JUN 12, 1915*

20-UNDERTAKER *Commissioner Health* ADDRESS.....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 14 1915
 Filed.....

ROBERT KRAUTER
 Registrar

FOR ANATOMICAL PURPOSES.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH *At Elmhurst Home*
CITY OF BALTIMORE: (No. *4*) ST.: *4* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Lillian May Smith*
(Residence in Baltimore: No. *St. Paul St.* St.: *4* yrs. *4* mos. *26* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH *Jan 10, 1915*
(Month) (Day) (Year)
7-AGE *4* yrs. *26* mos. *26* ds. or min. If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

JUN 14 1915

15-

Filed *1915*

ROBERT J. KRATZ
Burial Permits Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 12, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 10, 1915* to *June 12, 1915*, that I saw her alive on *June 11, 1915*, and that death occurred, on the date stated above, at *2* m.
The CAUSE OF DEATH* was as follows:

Enteritis Follicularis

(Duration) yrs. mos. *7* ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *Edgar A. Friedland* M. D.
June 12, 1915 [Address] *1016 Linden Ave*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, HOMICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death... yrs. *1* mos. *2* ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

HOPKINS HOSPITAL

20-UNDERTAKER

3001 Resner Heath

DATE OF BURIAL

JUN 14 1915

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1728*)

2-FULL NAME

(Residence in Baltimore: No. *741 Pierce St*)

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

(Month) (Day) (Year) *1*

7-AGE.

32 yrs. *7* mos. *7* da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *X*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....

JUN 14 1915

ROBERT E. KRAUSE

Hospital Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 10, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *June 9, 1915*, to *June 10, 1915*, that I saw her alive on *June 10, 1915*, and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) *7* yrs. *7* mos. *7* da.

CONTRIBUTORY (Secondary)

(Signed) *Dr. J. H. Smith* M. D.
June 11, 1915 (Address) *712 Park Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs. *0* mos. *2* da. In the State *0* yrs. *0* mos. *0* da.

Where was disease contracted, if not at place of death?

Former or usual residence *741 Pierce St*

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL

DATE OF BURIAL, JUN 11 1915

20-UNDERTAKER, COMMISSIONER HEALTH

ADDRESS

FOR ANATOMICAL PURPOSES.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86052 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH
REGISTERED NO. C. X170 C86052

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Theodore Engel*
(Residence in Baltimore: No. *College Park, Maryland* St. *65* yrs. *6* mos. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-MARRIED *Married*
OR WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH *Jan. 23, 1851*
(Month) (Day) (Year)
7-AGE *64* yrs. *4* mos. *22* ds. or *1* day, *1* hrs. *22* min.?
8-OCCUPATION (a) Trade, profession or particular kind of work *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *N. J.*
PARENTS
10-NAME OF FATHER *Henry Engel*
11-BIRTHPLACE OF FATHER (State or country) *Germany*
12-MAIDEN NAME OF MOTHER *Mary Ann Horne*
13-BIRTHPLACE OF MOTHER (State or country) *Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Dr. Phelps*
(Address) *Johns Hopkins Hosp.*

15-*JUN 15 1915* HARRY O. ANDREWS,
Funeral Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 14, 1915*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I attended deceased from *April 26, 1915*, to, *June 14, 1915*,
that I saw him alive on *June 14, 1915*,
and that death occurred, on the date stated above, at *6:50* m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Duration) *21* yrs. *10* mos. *10* ds.
Contributory (SECONDARY) *Chronic nephritis*
(Duration) *10* yrs. *10* mos. *10* ds.
(Signed) *Staubert Bayne Jones* M. D.
June 14, 1915 [Address] *Johns Hopkins Hospital*
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death *49* yrs. *4* mos. *15* ds. State *Pa.*
Where was disease contracted, if not at place of death?
Former or usual residence *College Park, Md.*

19-PLACE OF BURIAL OR REMOVAL *St. Agatha's* DATE OF BURIAL *June 15, 1915*
20-UNDERTAKER *W. F. ...* ADDRESS *...*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86053

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1931 Smallwood* ST.; *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME

(Residence in Baltimore: No. *1731 Smallwood* St. *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH.

Dec 23 - 1857
(Month) (Day) (Year)

7-AGE.

57 yrs. *5* mos. *21* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country), *Baltimore*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country), *Pa*

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country), *Don't Know*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Carrie Goodman*(Address) *1731 Smallwood*

15-

JUN 15 1915

HARRY O. ANDREWS,

191. Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 13, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

June 5, 1915, to June 13, 1915
that I saw him alive on *June 13, 1915*and that death occurred, on the date stated above, at *37* m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Fatty Degeneration of heart*

(Duration) yrs. mos. ds.

(Signed) *Robert E. Blake* M. D.*June 14, 1915.* (Address) *1014 W. 10th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Lorraine Park**June 15, 1915*

20-UNDERTAKER.

ADDRESS

*H. C. Kidfield**1014 W. 10th St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86054

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86054

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Cambridge ST.; 1 WARD)

REGISTERED NO. C

2-FULL NAME

Annie Wise

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2204 Cambridge St.; 1 yr., 11 mos., 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single
(Write the word.)

6-DATE OF BIRTH

July1, 1915
(Day) (Year)

7-AGE

7 yrs., 11 mos., 14 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).None
Child9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

John Wise11-BIRTHPLACE OF FATHER
(State or Country),Baltimore

12-MAIDEN NAME OF MOTHER

Mary Stogel13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

John Wise

(Address),

2204 Cambridge

15-

Filed

JUN 15 1915

HARRY O. ANDREWS,

191... Marital Permit... Oler
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June14, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 27 1915, to June 14 1915.that I saw him alive on June 7 1915,and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia & enteritis
(Broncho)

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)Cardiac exhaustion

(Duration) ... yrs. ... mos. ... ds.

(Signed) D. L. Cunningham M. D.June 13 1915. (Address) 7013 B. Ave. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

June 16, 1915.

20-UNDERTAKER

William Fialkowski

ADDRESS

1618 Eastern Ave.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4318 Dallas* ST.; *3* WARD)

2-FULL NAME

(Residence in Baltimore: No. *4318 Dallas* St.; yrs. mos. *2* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and add out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH

June 13, 1915
(Month) (Day) (Year)

7-AGE

If LESS than 1 day, ... hrs. or ... min.?
yrs. mos. *2* ds.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Bathurst

10-NAME OF FATHER,

Joseph Blazek

11-BIRTHPLACE OF FATHER (State or Country),

Russia Poland

12-MAIDEN NAME OF MOTHER

Mary Gruzewsky

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alex. A. Sienkiewicz*(Address) *131 S. Broadway*

15-

JUN 15 1915 HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 13, 1915, to June 14, 1915*that I saw her alive on *June 14, 1915*and that death occurred, on the date stated above, at *4A m.*

The CAUSE OF DEATH* was as follows:

chagrin was accidental to birth(Duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Alex. A. Sienkiewicz* M. D.*June 15, 1915* (Address) *131 S. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *2* ds. In the State yrs. mos. *2* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

June 15, 1915

20-UNDERTAKER

M. J. Sudowski

ADDRESS

405 S. Ann St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86056

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86056

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *122 Calvin*)

ST. *5* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and RR cut No. 12.)

2-FULL NAME *Dave Tath*

Residence in Baltimore: No. *122 Calvin*

St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

Unknown, 1

(Month)

(Day)

(Year)

7-AGE

60

yrs.

mos.

ds.

or

min.?

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Cook

9-BIRTHPLACE

(State or country)

Unknown

10-NAME OF FATHER

Unknown

11-BIRTHPLACE

OF FATHER

(State or country)

Unknown

12-MAIDEN NAME

OF MOTHER

Unknown

13-BIRTHPLACE

OF MOTHER

(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. C. Gross

(Address)

1405 McElderry St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June *12*, 191*5*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 7, 191*5*, to *June 12*, 191*5*,

that I saw him alive on *June 11*, 191*5*,

and that death occurred, on the date stated above, at *1:30 P. M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)

yrs.

mos.

21

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

Robert J. Green

M. D.

June 14, 191*5* (Address) *120 1/2 Paiswick St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asbury Cemetery

June 15, 191*5*

20-UNDERTAKER

ADDRESS

R. C. Gross 1405 McElderry St

JUN 15 1915

HARRY O. ANDREWS,

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C86057

156

C86057

PLACE OF DEATH

CITY OF BALTIMORE (No. *216 N. Glover*)

ST.:

WARD)

REGISTERED NO. C

FULL NAME

Isaac Croswell

Residence in Baltimore: No. *216 N. Glover*

St. *45* yrs., *1* mos., *1* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)

6-DATE OF BIRTH, *May 24, 1854* (Month) (Day) (Year)

7-AGE, *61* yrs., *2* mos., *21* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Carpenter* (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Pa*

10-NAME OF FATHER, *Wm Croswell*

11-BIRTHPLACE OF FATHER (State or Country), *Pa*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Pa*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Amie E. Croswell*

(Address) *216 N. Glover St*

15- *HARRY O. ANDREWS,*

Filed *JUN 15 1915* 191 *Barth H. Smith* Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 14, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide - Illuminating Gas (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....

(Signed) *Edgar J. Russell* (Coroner.) M. D.

June 14, 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Mount Carmel Cem.* DATE OF BURIAL, *June 16, 1915*

20-UNDERTAKER, *H. Vander Lous* ADDRESS, *1710 Fleet St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86058

C86058

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2420 Fleet* ST.; *1* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *2420 Fleet* St.; *Life* yrs., *Life* mos., *Life* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out (No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Sept 19th, 1854
(Month) (Day) (Year)

7-AGE,

60 yrs. 8 mos. 23 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Pool Room Proprietor

9-BIRTHPLACE, (State or Country),

Baltimore M.d.

10-NAME OF FATHER,

August Kremer

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Maria Gottliker

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Katherine Kremer*(Address) *2420 Fleet St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *May 15* 191*5*, to *June 12* 191*5*, that I saw him alive on *11* 191*5*, and that death occurred, on the date stated above, at *2 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *C. J. Rees* M. D.
614 1/2 St. 101 (Address) *Hopewell Ave.*

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Calvary Cem.

DATE OF BURIAL,

June 15, 1915

20-UNDERTAKER

H. Sander

ADDRESS,

1210 Fleet St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15-

JUN 15 1915

HARRY O. ANDREWS,

Bureau of Health

C86059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C86059

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *130 St Pleasant* ST. *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *130 St Pleasant* St. *4* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Colored**Married*
(Write the word.)

5-DATE OF BIRTH.

unknown
(Month) (Day) (Year)

7-AGE.

50

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Domestic*9-BIRTHPLACE.
(State or Country),*NC*

10-NAME OF FATHER,

*unknown*11-BIRTHPLACE OF FATHER
(State or Country)*unknown*

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Albert Waters*(Address) *130 N. Pleasant St.*

15-

JUN 15 1915

HARRY O. ANDREWS,

Filed..... 191.. *Baptist* Permit *0191*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 8* 191*5*, to *June 12* 191*5*, that I saw him alive on *June 11* 191*5*, and that death occurred, on the date stated above, at *6:50* m.

The CAUSE OF DEATH* was as follows:

Paralysis
Bright's Disease
(Duration) *1 yr. 11 mos.*

CONTRIBUTORY

Heart (Duration) *4 yrs. 4 mos. 4 ds.*(Signed) *W. H. Keen**June 14* 191*5* (Address) *708 E. Madison St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel East

DATE OF BURIAL,

June 15, 1915

UNDERTAKER

Robt A Elliott

ADDRESS

506 East St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86060

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86060

CERTIFICATE OF DEATH

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 N. Central av. St. 5 WARD)

2-FULL NAME

Clara Roanz

(Residence in Baltimore: No. 423 N. Central av. St. — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

unknown, 1

7-AGE

47 yrs. mos. ds. or mo.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

at home
Housewife

9-BIRTHPLACE

(State or country)

Ind.

10-NAME OF FATHER

Joseph Jackson

11-BIRTHPLACE OF FATHER

(State or country)

Ind.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Roanz

(Address)

423 N. Central av.

15-

JUN 15 1915

HARRY O. ANDREWS,

BURIAL PERMIT CLERK.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 13, 1915

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1915, to June 5, 1915, that I saw her alive on June 5, 1915, and that death occurred, on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of right breast.
(Clinical Diagnosis)

(Duration) 8 mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Robert J. Green M. D.
June 14, 1915 (Address) 120 1/2 Aisquith St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Laure Lane

DATE OF BURIAL

June 15, 1915

20-UNDERTAKER

Robt A Elliott

ADDRESS

506 East St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86061

CERTIFICATE OF DEATH.

113

C86061

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1918 N. Washington* ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 38.)

2-FULL NAME

(Residence in Baltimore: No. *1918 N. Washington* St.; *52* yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

Single

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Feb 25th 1863
(Month) (Day) (Year)

7-AGE,

52 yrs. *3* mos. *18* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

*Carrage**Painter*9-BIRTHPLACE,
(State or Country),*City*10-NAME OF
FATHER,*Edw. R. Poole*11-BIRTHPLACE
OF FATHER
(State or Country),*W. Va*12-MAIDEN NAME
OF MOTHER*Susan J. Gager*13-BIRTHPLACE
OF MOTHER
(State or Country),*Pa*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Margaret Poole*(Address) *1918 N. Washington St.*

15-

FILED

JUN 15 1915

HARRY O. ANDREWS,

Bureau of Health, City of Baltimore,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15th 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 31 1915, to *June 15 1915*,that I saw him alive on *June 14 1915*,and that death occurred, on the date stated above, at *3 P.M.*

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

.....

..... (Duration) yrs. *8* mos. ds.CONTRIBUTORY..... *exhaustion*.......... (Duration) yrs. *1* mos. ds.(Signed) *H. Robert Ketch* M. D.*June 15, 1915* (Address) *1509 N. Fayette St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL,

June 17, 1915

ADDRESS

723 Whelan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHILE FILLING IN, WITH UNFOLDING TAB, THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

7402 ✓
C86062 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH 20 C86062

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1413 Jefferson St. 5 WARD)
2-FULL NAME Maud C. Heath
(Residence in Baltimore: No. 1413 Jefferson St. 45 yrs. - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and RM out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female
4-COLOR OR RACE Colored
5-SINGLE MARRIED WIDOWED OR DIVORCED Single
6-DATE OF BIRTH June 1870
7-AGE 35 yrs. - mos. - ds. If LESS than 1 day, hrs., or min.?
8-OCCUPATION Landlady
9-BIRTHPLACE (State or country) Baltimore Ind
10-NAME OF FATHER Edward Heath
11-BIRTHPLACE OF FATHER Ind
12-MAIDEN NAME OF MOTHER Mary Thomas
13-BIRTHPLACE OF MOTHER Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas G. Bailey
(Address) 1421 Jefferson St

15-JUN 15 1915 HARRY O. ANDREWS,
Filed 191 Burial Permit Clerk,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 13-1915
17- I HEREBY CERTIFY, That I attended deceased from June 3, 1915, to June 13-1915, that I saw her alive on June 13-1915, and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

Septicæmia
from punctured wound
of foot (see splints in foot)
Contributory Acute Pleurisy
(Duration) 7 yrs. - mos. - ds.
(Signed) H. H. Harris M. D.
June 17-1915 [Address] 1416 Jefferson St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death... yrs... mos... ds. In the State... yrs... mos... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Adams Cemetery
DATE OF BURIAL June 16-1915
20-UNDERTAKER Chas G. Bailey
ADDRESS 1421 Jefferson St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86063

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86063

CERTIFICATE OF DEATH

1. PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1634 Holbrook ST. 9 WARD)

2. FULL NAME August Treff

(Residence in Baltimore: No. 1634 Holbrook St.; yrs. mos. 4 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH June 11, 1915
(Month) (Day) (Year)

7. AGE 4 yrs. 4 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION None.
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country) Balto

10. NAME OF FATHER Gotthardt T. Treff

11. BIRTHPLACE OF FATHER (State or country) Balto

12. MAIDEN NAME OF MOTHER Mary W. Wagner

13. BIRTHPLACE OF MOTHER (State or country) Balto

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gotthardt Treff

(Address) 1634 Holbrook St

15. JUN 15 1915 HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11, 1915, to June 12, 1915, that I saw him alive on June 14, 1915, and that death occurred, on the date stated above, at 6:30 a.m. The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration) 5 hrs yrs. mos. ds.

Contributory (SECONDARY) None
(Duration) yrs. mos. ds.
(Signed) Geo. T. Karp M. D.
June 15, 1915 (Address) Charles & Center St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Loudon Park Cemetery DATE OF BURIAL June 15, 1915

20. UNDERTAKER E. Schloman & Son ADDRESS 1039 Hanover

HEALTH DEPARTMENT—CITY OF BALTIMORE

086064

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Fremont Ave 15 ST. WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1410 Fremont Ave St. — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-MARRIAGE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Single

6-DATE OF BIRTH,

Nov 22

1914

(Month)

(Day)

(Year)

7-AGE,

6 yrs. 32 mos.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Md

10-NAME OF FATHER,

Saverio Scalia

11-BIRTHPLACE OF FATHER (State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Marie Calderone

13-BIRTHPLACE OF MOTHER (State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Saverio Scalia

(Address)

1410 Fremont Ave

15-

JUN 15 1915

Filed

191

HARRY O. ANDERSON,

Bureau of Health, City of Baltimore

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 13th

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

6/11 1915, to 6/13 1915,

that I saw him alive on 6/13 1915,

and that death occurred, on the date stated above, at 7^h m.

The CAUSE OF DEATH* was as follows:

acute gastric enteritis

(Duration) ... yrs. ... mos. ... 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

191... (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Cathedral Cemetery 15, 1915

20-UNDERTAKER

ADDRESS

Martin Fabry, 1006 Lafayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103

C86065

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1625 Friendsbury* ST.; *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1H.)

2-FULL NAME *Francis Robert Everett*(Residence in Baltimore: No. *1625 Friendsbury* St.; *50* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED, *married*

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH

December 6th, 1841
(Month) (Day) (Year)

7-AGE

73 yrs., *6* mos., *8* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Outlook*(b) General nature of industry, business, or establishment in which employed (or employer). *Insurance*

9-BIRTHPLACE,

(State or Country), *Spencer N. Y.*10-NAME OF FATHER, *Martin Everett*

11-BIRTHPLACE OF FATHER

(State or Country), *Spencer N. Y.*12-MAIDEN NAME OF MOTHER *Maria Bogget*

13-BIRTHPLACE OF MOTHER

(State or Country), *Spencer N. Y.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annie M. Everett*(Address) *1625 Friendsbury*

15-

JUN 15 1915

HARRY O. ANDREWS,

Filed....., 191..

Serial Form 11, 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 14th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 14th 1915, to *June 14th 1915*,that I saw him alive on *June 14th 1915*,and that death occurred, on the date stated above, at *7:35 a.m.*

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart
(Duration) ... yrs. ... mos. ... *minutes*

CONTRIBUTORY (Secondary)

Acute Catarrh of Prostate
(Duration) ... yrs. ... mos. ... *5 yrs.*(Signed) *William J. Williams**June 15, 1915*, (Address) *1701 N. Fulton Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

National Cem June 16, 1915

20-UNDERTAKER

ADDRESS *916**Daniel Carson* *Carson*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *811 Stockholms* ST. *21* WARD)

2-FULL NAME *Sarah Payne*

(Residence in Baltimore: No. *811 Stockholms* St. *38* yrs. *8* mos. *15* ds.)

REGISTERED NO. C. *92 C86066*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RR out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*

4-COLOR OR RACE *Colored*

5-SINGLE *Married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Oct 1*

(Month) (Day) (Year)

7-AGE *38*

yrs. *8* mos. *15* ds. or min.?

If LESS than
1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

Bald mo

PARENTS

10-NAME OF FATHER

Peter Butler

11-BIRTHPLACE OF FATHER
(State or country)

Md.

12-MAIDEN NAME OF MOTHER

Sarah Melhains

13-BIRTHPLACE OF MOTHER
(State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Sal Payne*

(Address) *811 Stockholms*

15-

Filed

JUN 15 1915

191

ROBERT J. KRAUTER

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Jun 13, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jun 5, 191*5*, to, *Jun 13*, 191*5*;

that I saw her alive on *Jun 12*, 191*5*;

and that death occurred, on the date stated above, at *9:45 a.m.*

The CAUSE OF DEATH* was as follows:

Robert Pneumonia

Contributory
(SECONDARY)

(Signed) *J. J. G. G. G.*

Jun 13, 191*5* [Address] *117 W. Maryland St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Peter's Cemetery

20-UNDERTAKER

Frederick B. Payne

DATE OF BURIAL

June 16, 191*5*

ADDRESS

107 E. Hamilton St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86067

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

713 Belgian Ave. 9

WARD)

2-FULL NAME

James E. Costello

(Residence in Baltimore: No.

713 Belgian Ave

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH.

Nov 21, 1849

(Month)

(Day)

(Year)

7-AGE.

65 4

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Lithographer

9-BIRTHPLACE.

(State or Country).

Canada

10-NAME OF FATHER.

Nicholas Costello

11-BIRTHPLACE OF FATHER.

(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER.

Mary O'Brien

13-BIRTHPLACE OF MOTHER.

(State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

J. E. Costello

(Address).

713 Belgian Ave

15-

MAR 23 1915

ROBERT . KRAUTER

Burial Permit Clerk

FUGATE

James 15/15

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

March 22, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from March 17 1915, to March 22 1915, that I saw him alive on March 22 1915, and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Oedema Lungs

(Signed) Reginald J. Tamm, M. D.

Mar 22 1915 (Address) 414 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

London Ont. Canada

3/23, 1915

20-UNDERTAKER

ADDRESS

Chas. H. Warrick 118 W. 1st St. N.Y.C.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86068 HEALTH DEPARTMENT—CITY OF BALTIMORE

C86068

CERTIFICATE OF DEATH.

151
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* 8

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Bobby Jones*Residence in Baltimore: No. *1609 E. Central*

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.) *Single*

6-DATE OF BIRTH.

June 8, 1915
(Month) (Day) (Year)

7-AGE,

*—**—**4**ds.*

If LESS than 1 day.

— hrs. or *—* min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *—*(b) General nature of industry, business, or establishment in which employed (or employer). *—*

9-BIRTHPLACE,

(State or Country). *Ind.*10-NAME OF FATHER, *Clarence Jones*

11-BIRTHPLACE OF FATHER

(State or Country). *Ind.*12-MAIDEN NAME OF MOTHER *Rose Brown*

13-BIRTHPLACE OF MOTHER

(State or Country). *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUN 15 1915

JOHNS HOPKINS HOSPITAL

Filed *20*

191

ROBERT

KRAUTER,

Burial Permit *Order*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*JUN 14 1915*20-UNDERTAKER *Commissioner Health*

ADDRESS

FOR ANATOMICAL PURPOSES.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Chrt. Ay.* ST.: *14* WARD)

REGISTERED NO. C

FULL NAME

Bernard Thibon

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. *St. Vincent's Chrt. Ay.* St.: yrs. *2* mos. *5* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

Jan. 10th, 1915.
(Month) (Day) (Year)

7-AGE,

5 yrs. 5 mos. 5 da.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*15- JUN 15 1915 ROBERT KRAUTER,
Filed..... 191... *Curial Permit Office*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15th, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
June 1st 1915, to *June 14 1915*,
that I saw him alive on *June 14 1915*,
and that death occurred, on the date stated above, at *3 a. m.*
The CAUSE OF DEATH* was as follows:*Broncho-pneumonia*(Duration) yrs. mos. *4* da.CONTRIBUTORY.....
(Secondary)*Malnutrition*

(Duration) yrs. mos. da.

(Signed) *Elmer G. Hall* M. D......, 191... (Address) *16128. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. da. In the State yrs. *5* mos. *5* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral

DATE OF BURIAL,

June 16 1915

20-UNDERTAKER,

H. C. Knudsen

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1211 Jefferson* ST. *5* WARD)

FULL NAME

(Residence in Baltimore: No. *1211 Jefferson* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

widow

6-DATE OF BIRTH,

February 1
(Month) (Day) (Year)

7-AGE,

65 yrs. *—* mos. *—* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Domestic at home*9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Marie Rigdon*(Address) *1211 Jefferson St.*

15-

JUN 15 1915

ROBERT KRAUTER,

Filed *1915* *Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12, 191*5*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 7 191*5*, to *June 12* 191*5*that I saw him alive on *June 12* 191*5*and that death occurred, on the date stated above, at *1:15* p. m.

The CAUSE OF DEATH* was as follows:

*Mitral Stenosis,**unknown* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Atrophic curiosis of Liver
unknown (Duration) yrs. mos. ds.(Signed) *Edward Fisher* M. D.*June 12, 1915* (Address) *1612 E. Monument St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asbury cemetery *June 16*, 191*5*

20-UNDERTAKER

ADDRESS

W. D. Gross *1405 McAdams St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103 C86071

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 N. Luzerne Ave. WARD)FULL NAME Theresa Hippmann(Residence in Baltimore: No. 820 N. Luzerne Ave. St.; 70 yrs., 6 mos. 1 da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow
(Write the word.)

6-DATE OF BIRTH. Dec 6, 1 (Month) (Day) (Year)

7-AGE. 78 yrs. 6 mos. 1 da. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). Housework

9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, Bittner11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis X. Hippmann
(Address) 820 N. Luzerne St.

15- JUN 15 1915 ROBERT KRAUTER, REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 13 1915, to June 13 1915, that I saw her alive on June 13 1915, and that death occurred, on the date stated above, at 12:45 m. The CAUSE OF DEATH* was as follows:

Gastritis
(Duration) 6 yrs. 6 mos. 14 da.

CONTRIBUTORY (Secondary) Inanition

(Signed) J. H. Grollenberg M. D.
June 14, 1915 (Address) 1810 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. 6 mos. 14 da. In the State 1810 E. Baltimore

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem.DATE OF BURIAL, June 15, 191520-UNDERTAKER Lilly ZeilerADDRESS 4038 W. Mifflin

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86072

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 N. Luzerne ST.; 6 WARD)

REGISTERED NO. C

FULL NAME

Margaret Berger (Berger)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 112 N. LuzerneSt.; 75 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

December, 1834
(Month) (Day) (Year)

7-AGE,

81 yrs., mos., da.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework9-BIRTHPLACE,
(State or Country),Germany

10-NAME OF FATHER,

John Beil11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Margt. Knoerlein13-BIRTHPLACE OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Quinn(Address) 112 N. Luzerne St.

15-

JUN 15 1915 ROBERT KRAUTH
FILED 112 N. Luzerne St. Regist.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 1 1915, to June 15 1915, that I saw her alive on June 13 1915, and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

Bright Kidney Disease
(Duration) 2 yrs., 1 mos., da.CONTRIBUTORY
(Secondary)(Signed) A. C. Heiser M. D.
June 15, 1915. (Address) 2000 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., da. In the State yrs., mos., da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Holy Redeemer Cem June 18, 1915.

20-UNDERTAKER

ADDRESS

Lily and John 4038 Maple

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *819 N Collington Ave*)

2-FULL NAME *Frances A Healy*

(Residence in Baltimore: No. *819 N Collington Ave*)

St. *7*

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Nov 23rd, 1891
(Month) (Day) (Year)

7-AGE,

23 yrs. 6 mos. 22 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE, (State or Country),

MD

10-NAME OF FATHER,

Charles Kasik

11-BIRTHPLACE OF FATHER (State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Antonia Pospisil

13-BIRTHPLACE OF MOTHER (State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elmer Healy*

(Address) *819 N Collington Ave*

15-

Filed

JUN 15 1915

ROBERT KRAUTER

Barial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.)

and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Criminal Abortion*

(Duration) yrs. mos. ds.

(Signed) *Oliver L. Russell* M. D. (Coroner.)

June 10th, 1915 (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral

June 15, 1915

20-UNDERTAKER

ADDRESS

William Cook

502 N Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUN 15 1915

ROBERT KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

February 1915, to June 15 1915,

that I saw him alive on June 15 1915,

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Upper Esophagus (at anastomosis) (Duration) 3 yrs. 6 mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) 3 yrs. 6 mos. 15 ds.

(Signed) M. R. Levine M. D.

June 15, 1915. (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 6 yrs. 6 mos. 15 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 130 N. Curley St.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Hosp. 1915...

20-UNDERTAKER

ADDRESS

W. C. Cook 502 E. Bay

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *Ma General Hospital* ST. *12* WARD)FULL NAME *Mrs. Irene Steigewald*(Residence in Baltimore: No. *2802 Bernard St* St.; *12* yrs., *12* mos., *15* da.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Sept 1, 1883
(Month) (Day) (Year)

7-AGE,

*32**7* yrs., *7* mos., *7* da.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

At Home

9-BIRTHPLACE, (State or Country),

Mayland

10-NAME OF FATHER,

George R. Chalk

11-BIRTHPLACE OF FATHER (State or Country),

unintable

12-MAIDEN NAME OF MOTHER

Parah Crosby

13-BIRTHPLACE OF MOTHER (State or Country),

Mayland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. I. Steigewald*(Address) *3561 Cedar Ave*

15 JUN 15 1915, ROBERT E. KRAUTER, Serial Permit Clerk, Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 4, 1915*, to *June 15, 1915*, that I saw her alive on *June 15, 1915*, and that death occurred, on the date stated above, at *9:15 AM*.

The CAUSE OF DEATH* was as follows:

Cardiac Failure(Duration) *7* yrs., *7* mos., *7* da.

CONTRIBUTORY (Secondary)

Robert Pneumonia(Duration) *9* yrs., *9* mos., *11* da.(Signed) *J. S. Fischer* M. D......, 191... (Address) *Baltimore, Md.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs., *0* mos., *11* da. In the State *12* yrs., *12* mos., *15* da.

Where was disease contracted, if not at place of death?

Former or usual residence *2802 Bernard St*

19-PLACE OF BURIAL OR REMOVAL,

Loudon Park

DATE OF BURIAL,

6/17, 1915

20-UNDERTAKER

William Cook

ADDRESS

102 E. North

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86076

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 C86076
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Asylum* ST.; *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Chene Herkenheims*(Residence in Baltimore: No. *St. Vincent's Asylum* St.; yrs. / mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

April 26th, 1915.
(Month) (Day) (Year)

7-AGE,

1. mos. 19 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

Edmond Herkenheims

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Amelia Stube

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St*

JUN 16 1915

HARRY O. ANDREWS,

Filed 191... *1915* *1401 Division St*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 14th, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 1st* 1915, to *June 14* 1915, that I saw her alive on *June 14* 1915, and that death occurred, on the date stated above, at *10 P. m.* The CAUSE OF DEATH* was as follows:*Intestinal intoxication*
(Duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

Malnutrition
(Duration) yrs. / mos. ds.(Signed) *Chene G. Hall* M. D.101... (Address) *1617 E. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. / mos. 19 ds. In the State yrs. / mos. 19 ds.

Where was disease contracted, if not at place of death?

Former or usual residence *St Vincent's Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Carmel Cem. *June 16 1915.*

20-UNDERTAKER

ADDRESS

Monte Fayerdon. *606 Lafayette*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C86077 151 C86077

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.: *14* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Robert Scott*

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs. *2* mos. *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)

6-DATE OF BIRTH, *April 2nd, 1915*
(Month) (Day) (Year)

7-AGE, yrs. *2* mos. *12* ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country), *Maryland*

PARENTS.

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*
(Address) *1401 Division St.*

15-

Filed *6161 91 NDC* JUN 16 1915 HARRY O. ALLEN, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 14th, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 1st* 1915, to *June 14th* 1915, that I saw him alive on *June 14th* 1915, and that death occurred, on the date stated above, at *4.30 P.M.* The CAUSE OF DEATH* was as follows:

In administration and mal assimilation
(Duration) yrs. *2* mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Elmer G. Hall* M. D.
(Address) *1612 E. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. *2* mos. *12* ds. In the State yrs. *2* mos. *12* ds.

Where was disease contracted, if not at place of death? *St. Vincent's Infant Asylum*
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cathedral* DATE OF BURIAL, *June 16, 1915*
20-UNDERTAKER, *Martin Raby & Son* ADDRESS, *606 Lafayette Ave.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 12.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.,

or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

JUN 16 1915

HARRY O. AUSTIN

Marial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

5727, 1915, to, 6/14 1915,

that I saw her alive on 6/14 1915,

and that death occurred, on the date stated above, at 7:07 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Contributory
(SECONDARY)

(Signed),

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. in the State, yrs. mos. ds.

Where was disease contracted, If not at place of death? 9 N. Eder st

Former or usual residence 9 N. Eder st

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Rosedale June 16, 1915

20-UNDERTAKER

ADDRESS

S. Dunson Bros Balto st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86079

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86079

CERTIFICATE OF DEATH.

155

1-PLACE OF DEATH *Franklin Sq. Hopt. ST.*
CITY OF BALTIMORE (No. *20* WARD)
2-FULL NAME *Frederick W. Rettman*
(Residence in Baltimore: No. *2631 Hafer*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *1* mo. *1* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)
6-DATE OF BIRTH, *Oct. 4th, 1894*
(Month) (Day) (Year)

7-AGE, *23* yrs. *8* mos. *10* da.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Day Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer), *Driver*

9-BIRTHPLACE, (State or Country), *Md. (Balt. City)*

10-NAME OF FATHER, *Frederick Rettman*

11-BIRTHPLACE OF FATHER, (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Augustine Schmitz*

13-BIRTHPLACE OF MOTHER, (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annie Rettman*
(Address) *2631 Hafer St.*

15- *JUN 16 1915* *HARRY O. ANDREWS,*
Filed *1915* *Serial Permit Clerk*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 14th, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry*
(Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Acid Poisoning
Success
(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... da.
(Signed) *Sam'l Hunter* M. D.
June 16th, 1915 (Address) *2302 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... da. State *23* yrs. ... mos. ... da.

Where was disease contracted, if not at place of death? ...

2631 Hafer St.
Former or usual residence *2631 Hafer St.*

19-PLACE OF BURIAL, OR REMOVAL, *Evangelical Cem.* DATE OF BURIAL, *June 17th, 1915*

20-UNDERTAKER *H. Sander* ADDRESS *1710 E. 11th St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86080

C86080

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 1746 Webster)
FULL NAME Walter F Foxwell
(Residence in Baltimore: No. 1746 Webster)

ST. 24 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 6 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single
6-DATE OF BIRTH, Dec 1st, 1914
(Month) (Day) (Year)
7-AGE, 6 yrs. 6 mos. 14 ds.
If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Balto Md

PARENTS.

10-NAME OF FATHER, Walter F. Foxwell
11-BIRTHPLACE OF FATHER (State or Country) Cambridge Md
12-MAIDEN NAME OF MOTHER, Lizzie Glover
13-BIRTHPLACE OF MOTHER (State or Country) Cambridge Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Foxwell
(Address) 1746 Webster

15-JUN 16 1915 HARRY O. ANDREWS, Registrar.
Filed 191 Serial Permit 0101

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 15, 1914
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 ds.

(Signed) John S. Smith M. D. (Coroner.)

June 15, 1914. (Address) 517 Seaton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cape Lawn.

DATE OF BURIAL,

June 16, 1914

20-UNDERTAKER

Edw. J. Fanning

ADDRESS

1460 Battery Ave

C86081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *527 E. Fort Ave.* ST.; *24* WARD)

2-FULL NAME

(Residence in Baltimore: No. *527 E. Fort Ave.* St.; *72* yrs., *-* mos., *-* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

Unknown, *1873*
(Month) (Day) (Year)

7-AGE,

72 yrs., *-* mos., *-* ds.

If LESS than 1 day,

....hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

*None*9-BIRTHPLACE,
(State or Country),*Balto. Md.*10-NAME OF
FATHER,*John Bosten*11-BIRTHPLACE
OF FATHER
(State or Country),*Balto. Md.*12-MAIDEN NAME
OF MOTHER*Unknown*13-BIRTHPLACE
OF MOTHER
(State or Country),*Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Nora Dougherty

(Address)

527 E. Fort Ave.

15-

JUN 16 1915

HARRY O. ANDREWS,

MAYOR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 14, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1 1915, to *June 14* 1915,that I saw her alive on *June 14* 1915,and that death occurred, on the date stated above, at *5:20* a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Myocarditis (chronic)*

(Duration) yrs. mos. ds.

(Signed) *S. H. Streett* M. D.*June 14*, 1915. (Address) *431 E. Fort Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Beder Hill

DATE OF BURIAL,

June 16, 1915.

20-UNDERTAKER

Edw. J. Manning

ADDRESS

1460 Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86082

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 Boone St.; 9 WARD)

2-FULL NAME

Residence in Baltimore: No.

Miss Elizabeth Riston
2008 BooneSt. Life, mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White5-SINGLE, Single
MARRIED
WIDOWED
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

....., 1880
(Month) (Day) (Year)

7-AGE.

about 35If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....House work9-BIRTHPLACE,
(State or Country),Balto

10-NAME OF FATHER,

Lo B Riston11-BIRTHPLACE OF FATHER
(State or Country),Wilmington D C

12-MAIDEN NAME OF MOTHER

Mary J Cooney13-BIRTHPLACE OF MOTHER
(State or Country),Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Schenker
2008 Boone St

(Address)

15-

JUN 16 1915 HARRY O. ANDREWS,
Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 14, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 6 1915, to June 14 1915, that I saw him alive on June 14 1915, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

InfluenzaLobar (Pneumonia)

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) D. P. Bernard M. D.6/10, 1915. (Address) 914 E. Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

June 17, 1915

20-UNDERTAKER

Ed Wiedfeldt

ADDRESS

Chesapeake

14. b. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86083

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86083

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *541 W Mosher* St. *14* WARD)2-FULL NAME *Thomas E. Carter*Residence in Baltimore: No. *541 W Mosher St.*

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 10.)

St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Unknown

(Month)

(Day)

1870

(Year)

7-AGE

45

yrs.

mos.

ds.

If LESS than

1 day, hrs.

min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9-BIRTHPLACE

(State or country)

Md

10-NAME OF FATHER

Thomas Carter

11-BIRTHPLACE OF FATHER

(State or country)

Md

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *John Carter*(Address) *541 Mosher St.*

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

June

(Month)

13

(Day)

1915

(Year)

I HEREBY CERTIFY, That I attended deceased from

June 4, 1915, to *June 13*, 1915,that I saw him alive on *June 12*, 1915,and that death occurred, on the date stated above, at *2:45* p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

General debility and alcoholism

(Duration) yrs. mos. ds.

(Signed) *B. J. French* M. D.*June 14, 1915* (Address) *1707 E. Madison St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

16-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. Auburn**June 16, 1915*

20-UNDERTAKER

ADDRESS

James H. Denny, 303 Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 16 1915

HARRY O. ANDREWS,

Serial Permit Clerk,

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86084

C86084

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1360 N. Stricker* ST.; *15* WARD)

REGISTERED NO. C

2-FULL NAME *John Phillips*(Residence in Baltimore: No. *1360 N. Stricker* St.; — yrs. *10* mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH

Unknown, *1889*
(Month) (Day) (Year)

7-AGE

26 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Laborer/Unskilled*

9-BIRTHPLACE, (State or Country),

Va.

10-NAME OF FATHER

Newmore Phillips

11-BIRTHPLACE OF FATHER (State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Harriet Gayle

13-BIRTHPLACE OF MOTHER (State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Gayle*(Address) *1360 N. Stricker St.*

15-

JUN 16 1915 HARRY O. ANDREWS,
Filed.....*Burial Permit Clerk*.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 14, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 1, *1915*, to *June 14*, *1915*,that I saw him alive on *June 14*, *1915*,and that death occurred, on the date stated above, at *3 P.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *2* yrs. *2* mos. — ds.

CONTRIBUTORY (Secondary)

Lobar Pneumonia(Duration) *1* yr. *25* ds.(Signed) *Harry F. Brown* M. D.*June 15*, *1915* (Address) *1501 Presbman*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence ..

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Wt Auburn**June 17*, *1915*

20-UNDERTAKER

ADDRESS

James D. Dennis, *1303 Presbman*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S RECORD THIS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86085

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86085

CERTIFICATE OF DEATH.

1-PLACE OF DEATH **Maryland General Hospital,**
CITY OF BALTIMORE (No. **Linden ave. & Madison st.** ST. **16** WARD)
2-FULL NAME **Edward F. Doudiken,**
(Residence in Baltimore: No. **1119 N. Mount st.**

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., **4** mos. **19** ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. **Male,** 4-COLOR OR RACE, **White,** 5-SINGLE, MARRIED, **Married,**
WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, **January 26th, 1877.**
(Month) (Day) (Year)
7-AGE, **38** yrs. **4** mos. **19** ds. If LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. **House painter.**
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), **Maryland,**
10-NAME OF FATHER, **Joseph Doudiken,**
11-BIRTHPLACE OF FATHER (State or Country), **Maryland,**
12-MAIDEN NAME OF MOTHER **Virginia Sheets,**
13-BIRTHPLACE OF MOTHER (State or Country), **Maryland.**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) **Catherine V. Doudiken,**
(Address) **1119 N. Mount street.**

15- **JUN 16 1915** **HARRY O. ANDREWS,**
Filed. **191** **Marial Permit 410** Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, **June 14th, 1915.**
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an **Inquiry**
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said **Inquiry** and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Fracture of the skull caused by an accidental fall from a painter's cripple on which he was working. (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(Signed) **Harriet K. Hump** M. D.
(Coroner.)

June 15 1915. (Address) **3310 W. North ave.**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. ... yrs. ... mos. ... ds. In the State. ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, **New Cathedral** DATE OF BURIAL, **9/17**, 19...

20-UNDERTAKER **William Cook** ADDRESS **502 E. North**

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 N Mount ST.; 16 WARD)

REGISTERED NO. C

2-FULL NAME (Deceased) (Infant) Shaler

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1037 N Mount St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, June 15, 1915 (Month) (Day) (Year)

7-AGE, yrs., mos., ds. If LESS than 1 day, hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work,
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Baltimore Md

10-NAME OF FATHER, Geo. Shaler

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Pauline Disney

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JUN 16 1915 HARRY O. ANDREWS, JR.

Filed 1915 Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 15, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1915 to June 15 1915, that I saw h alive on 191 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature birth 6 mo before
same of premature birth
unknown
..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY..... (Secondary).....

..... (Duration)..... yrs..... mos..... ds.
(Signed) W. P. Dancy M. D.
6/15/15 101... (Address) 1953 N. Harb. an

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL DATE OF BURIAL JUN. 16 1915

20-UNDERTAKER Continental Health ADDRESS

FOR ANATOMICAL PURPOSES.

N. B.—Every item of information needed for tabulation supplied. AGE should be stated EXACTLY. PHYSICIAN'S RECORDS ARE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86087

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15-W-29th St. ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ellen Bowerman(Residence in Baltimore: No. 15-W-29th St. St.; 76 yrs., ? mos., ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow6-DATE OF BIRTH November 4, 1888
(Month) (Day) (Year)7-AGE, about 76 yrs., 7 mos., 11 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). none9-BIRTHPLACE, (State or Country), Baltimore City10-NAME OF FATHER, Thomas Horatio Bowerman11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER, Sarah J. McElroy13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Horatio B. Bowerman(Address) 15-W-29th St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16th, 1915.
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from March 1st 1915 to June 14th 1915, that I saw her alive on June 14th 1915, and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism & Dilatation of Heart.
with Mitral & Aortic insufficiencyCONTRIBUTORY (Secondary) Hypertensive Pneumonia
(Duration) 4 yrs., 2 mos., 2 ds.(Signed) Levil E. Stewart M. D.
June 15, 1915. (Address) 122 W. 28th St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

JUN 16 1915

HARRY O. ANDERSON,

191 Serial Permit Clerk

Registrar.

20-UNDERTAKER

St. John's P. E. Cemetery
Stewart & Mowen Co

ADDRESS

June 17th, 1915
108 W. North Ave.

N.B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86088

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86088

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 S. Bethel St. ST.;

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Joseph Ferraracci

(Residence in Baltimore: No. 720 S. Bethel St.

St.; Lifes. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

September 2, 1912
(Month) (Day) (Year)

7-AGE,

2

yrs. 9 mos. 13 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Joseph Ferraracci

11-BIRTHPLACE OF FATHER (State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Lary Brockland

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph Ferraracci

(Address)

720 S. Bethel St.

JUN 16 1915

HARRY O. ANDERSON,

Marial Permit Clerk.

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 12, 1915, to June 15, 1915,

that I saw him alive on June 14, 1915,

and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia - Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. T. Rice M. D.

June 15, 1915 (Address) 24 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery June 17, 1915

20-UNDERTAKER

ADDRESS

Louis W. Hermann 32 S. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1620 N. Wolfe St.* ST.: *8* WARD)2. FULL NAME *Franklin Oliver Myers*(Residence in Baltimore: No. *1620 N. Wolfe St.* St.: *8* yrs. *7* mos. *15* ds.)REGISTERED NO. C *119*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX *Male*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED, OR SEPARATED, (Write the word.) *Single*6. DATE OF BIRTH, *Aug 18, 1901*7. AGE, *13 yrs. 9 mos. 28 ds.*

If LESS than 1 day, ... hrs. or ... min.?

8. OCCUPATION:

(a) Trade, profession, or particular kind of work *School Boy*(b) General nature of industry, business, or establishment in which employed (or employer) *School Boy*9. BIRTHPLACE, (State or Country), *Maryland*

PARENTS.

10. NAME OF FATHER, *Charles Edward Myers*11. BIRTHPLACE OF FATHER (State or Country), *Maryland*12. MAIDEN NAME OF MOTHER *Ide May Lewis*13. BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles E. Myers*(Address) *1620 N. Wolfe St.*

JUN 16 1915

HARRY O. ANDREWS,

Filed *1915* *Surgeon-General* *Clark* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH, *June 15, 1915*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 21, 1915*, to *June 15, 1915*, that I saw him alive on *June 15, 1915*, and that death occurred, on the date stated above, at *11:20 P. m.*

The CAUSE OF DEATH* was as follows:

Nephritis Acute(Duration) *1* yrs. *6* mos. *1* ds.CONTRIBUTORY (Secondary) *Uremia*(Duration) *1* yrs. *6* mos. *1* ds.(Signed) *Isaac Fisher* M. D.*June 15, 1915* (Address) *1926 S. Long St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *6* mos. *1* ds. In the State *1* yrs. *6* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL, *Green Mount*DATE OF BURIAL, *June 19, 1915*20. UNDERTAKER *Joseph Cook*ADDRESS *1003 N. Balto St.*

Every item of information should be carefully supplied. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86090

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

103 C86090

PLACE OF DEATH

CITY OF BALTIMORE (No. 1506 Burrongh

REGISTERED No. C

ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Katie S. Herzberger*

(Residence in Baltimore: No. 1506 Burrongh

St. - yrs. - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

single

6-DATE OF BIRTH

Sept 6, 1904
(Month) (Day) (Year)

7-AGE

10 yrs. 7 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

md

10-NAME OF FATHER

Geo. H. Herzberger

11-BIRTHPLACE OF FATHER
(State or country)

md

12-MAIDEN NAME OF MOTHER

Katie Schmitt

13-BIRTHPLACE OF MOTHER
(State or country)

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Katie Schmitt*

(Address) *1506 Burrongh St.*

JUN 16 1915.

HARRY O. ARLEN
Marial Permit Officer

Filed , 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 13, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 8, 1915*, to *June 13, 1915*, that I saw her alive on *June 13, 1915*, and that death occurred, on the date stated above, at *11 p. m.* The CAUSE OF DEATH* was as follows:

Leukemia (acute)

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

M. D.

June 14, 1915 (Address) *578 ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Hill Cem. June 16, 1915

20-UNDERTAKER

ADDRESS

Robt. J. Turner 1442 N. Baby

C86091

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 N. Gilman ST.; 15 WARD)

REGISTERED NO. C

2-FULL NAME William Henry Hutchins(Residence in Baltimore: No. 1410 N. Gilman

St.: — yrs., — mos., — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Male

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH,

March 8, 1850
(Month) (Day) (Year)

7-AGE,

65 yrs. 3 mos. 7 ds.If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Manufacturer
Lumber9-BIRTHPLACE,
(State or Country).Catonsville, Maryland

10-NAME OF FATHER,

Samuel S. Hutchins11-BIRTHPLACE OF FATHER
(State or Country).Vermont

12-MAIDEN NAME OF MOTHER

Mary Brooks13-BIRTHPLACE OF MOTHER
(State or Country).Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Hutchins Jr.(Address) 1416 N. Gilman St.

15-

JUN 16 1915HARRY O. ANDREWS,Filed....., 1915 Serial Permit 4107

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
April 17 1915, to June 15 1915,
that I saw him alive on June 15 1915,
and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation and
Dilatation of Heart(Duration) — yrs. 2 mos. — ds.CONTRIBUTORY
(Secondary)Anasarea(Duration) — yrs. — mos. 6 ds.(Signed) Charles E. Clark M. D.June 15, 1915. (Address) 1310 N. Gilman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Landon Park Cmet

20-UNDERTAKER

Wilbur W. Shriver

DATE OF BURIAL,

June 17, 1915

ADDRESS

1712 N. Fulton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

12 LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country).10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country).12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at .. m.

The CAUSE OF DEATH* was as follows:

Dysentery of Liver (Clinical Diagnosis)

CONTRIBUTORY
(Secondary)

(Signed)

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

15-

JUN 16 1915

HARRY O. ANDREWS,

Filed....., 1915, Serial Permit Clerk,

Registrar.

Christian Miller

2334 Jefferson St.

N. B. Every informant should be carefully supplied. AGE, unless stated, should be in years. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 N. Chapel St. ST.; 8 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1031 N. Chapel St. St.; yrs., mos., da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

..... 6 26 1914
(Month) (Day) (Year)

7-AGE,

..... yrs. 11 mos. 16 ds.If LESS than 1 day,
..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),Italy

PARENTS.

10-NAME OF FATHER,

Andrew Potten11-BIRTHPLACE OF FATHER
(State or Country),Balto

12-MAIDEN NAME OF MOTHER

Stella Johnson13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother(Address) 1031 N. Chapel St.

15-

JUN 16 1915

ROBERT

KRAUTH

Filed.....

191

Burial Permit No. 1031

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

..... 6 15 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 13 1915, to June 15 1915, that I saw her alive on June 14 1915, and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Breath Pneumonia..... (Duration) yrs. mos. 6 ds.CONTRIBUTORY
(Secondary)Exhaustion..... (Duration) yrs. mos. 12 ds.(Signed) John H. ... M. D.June 16 1915. (Address) 1031 N. Chapel St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel CemaJune 17, 1915

20-UNDERTAKER

ADDRESS

Harry A. Voderly 1725 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. *3619 Greenmount Ave* ST.; *9* WARD)FULL NAME *Franklin Carl De Groves*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. *3619 Greenmount Ave*St.; *8* yrs., *1* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

August 16th, 1906
(Month) (Day) (Year)

7-AGE,

8 yrs., *10* mos., *0* ds. *10* LESS than 1 day.
.....hrs. or.....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE, (State or Country),

Ind.

10-NAME OF FATHER,

Frank De Groves

11-BIRTHPLACE OF FATHER (State or Country),

Ind.

12-MAIDEN NAME OF MOTHER

Lora Northington

13-BIRTHPLACE OF MOTHER (State or Country),

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lora De Groves*(Address) *3621 Greenmount Ave*

15-

*JUN 16 1915**ROBERT KRAUTER,**Serial Permit Clerk*

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 16th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 31st, 1915, to *June 16th, 1915*,that I saw him alive on *June 16th, 1915*,and that death occurred, on the date stated above, at *10:20 AM*.

The CAUSE OF DEATH* was as follows:

Tuberculosis(Duration).....yrs.....mos. *12* ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Geo. M. Montgomery, M. D.**June 16th, 1915* (Address) *3621 Greenmount Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn

DATE OF BURIAL,

6/19, 1915

20-UNDERTAKER

Miriam Cook

ADDRESS

122 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

086095

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 086095

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 N. Milton Ave. ST. 8 WARD)

2-FULL NAME Margaret A. Burns

(Residence in Baltimore: No. 1137 N. Milton Ave. St. 8 yrs. 40 mos. 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and IN out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

March 18, 1845
(Month) (Day) (Year)

7-AGE

70 yrs. 2 mos. 0 ds. or min. ? If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

at Home

9-BIRTHPLACE
(State or country)

York, Penna.

10-NAME OF FATHER

William H. Christine

11-BIRTHPLACE OF FATHER
(State or country)

Penn.

12-MAIDEN NAME OF MOTHER

Elizabeth Cooper

13-BIRTHPLACE OF MOTHER
(State or country)

Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bernard Burns

(Address) 1137 N. Milton Ave.

MEDICAL CERTIFICATE OF DEATH

15-DATE OF DEATH

June 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 23, 1915, to June 15, 1915, that I saw her alive on June 13, 1915, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Fatty Degeneration of Heart
Insufficiency of Aorta

Contributory
(SECONDARY)

Obesity

(Signed) R. P. Cannon M. D.

June 15, 1915 (Address) 1701 N. Caroline

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, If not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn

6/17, 1915

20-UNDERTAKER

ADDRESS

William Cook 502 E. North

15-

JUN 16 1915

ROBERT J. KRAUTER

Corial Permit Clerk

REGISTRAR

C86096

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 C86096
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 N. Hamburg St.; 21 WARD)

2-FULL NAME

(Residence in Baltimore: No. 527 N. Hamburg St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female 4-COLOR OR RACE: white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED: Married (Write the word.)

6-DATE OF BIRTH: unknown, 1 (Month) (Day) (Year)

7-AGE: 67 yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Housewife (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md.

10-NAME OF FATHER: James E. Crause

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Mary Hamilton

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. A. J. Kuber (Address) 527 N. Hamburg St.

15- JUN 16 1915 ROBERT KRAUSE, REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 15, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 10, 1915, to June 15, 1915, that I saw him alive on June 14, 1915, and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Indeterminate (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) uremia (Duration) yrs. mos. ds.

(Signed) R. R. Campbell, M. D. June 15, 1915 (Address) 1644 S. Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Laurel Md. June 17, 1915
20-UNDERTAKER: R. S. Turner ADDRESS: 1442 N. Bond St.

Every item of information should be carefully supplied. Accuracy is essential. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86097

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 2326 Etting street, ST. 13 WARD)

2-FULL NAME Stella Green alias Buoy,

(Residence in Baltimore: No. 2326 Etting street,

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female,	4-COLOR OR RACE, Colored,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single,
6-DATE OF BIRTH, February 28th, 1893. (Month) (Day) (Year)		
7-AGE, 22 yrs. 3 mos. 14 ds.		8-IF LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. Laundress. (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), Maryland,		
PARENTS.	10-NAME OF FATHER, John Green,	
	11-BIRTHPLACE OF FATHER (State or Country), New Jersey,	
	12-MAIDEN NAME OF MOTHER Hattie Buoy,	
	13-BIRTHPLACE OF MOTHER (State or Country), Maryland.	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Green, mother,

(Address) 2326 Etting street.

15-
JUN 16 1915
Filed

ROBERT KRAUTER,
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,
June 14th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to her death
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably
Valvular Heart disease.

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)(Signed) J. H. Humpal M. D.
(Coroner.)

June 15, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Owens Station, Calvert, June 17th, 1915.

20-UNDERTAKER ADDRESS

Felix B. Pyle 1128 Milbury

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86098

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1724 Barnes* ST.;

REGISTERED NO. C

2-FULL NAME

Emilia Smuk (Smuk)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. *1724 Barnes*

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

June 10, 1915
(Month) (Day) (Year)

7-AGE,

6
..... yrs. mos. ds.

If LESS than 1 day,

..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Josef Smuk

11-BIRTHPLACE OF FATHER (State or Country)

Bohemia

12-MAIDEN NAME OF MOTHER

Anna Jedlauer

13-BIRTHPLACE OF MOTHER (State or Country),

Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

Josef Smuk
1724 Barnes

15-JUN 16 1915.

ROBERT . KRAUTER

Filed..... 191.....

SPECIAL PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 14, 1915 to June 15, 1915*that I saw her alive on *June 16, 1915*and that death occurred, on the date stated above, at *4* m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

..... (Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary).....

..... (Duration)..... yrs. mos. ds.

(Signed) *A. J. ...* M. D.

6-15-15 (Address).....

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Oak Hill Cem

DATE OF BURIAL,

June 17, 1915

20-UNDERTAKER

Geo M. Fink

ADDRESS

811 N Wolfe

N. B.—Every item of information should be carefully supplied. AGE must be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2402 N. Charles St. ST. 11 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 30 East Lanvale St. St.; 10 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. married
(Write the word.)

6-DATE OF BIRTH

September 6th, 1848
(Month) (Day) (Year)

7-AGE

66 yrs., 9 mos., 11 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Government clerk9-BIRTHPLACE
(State or Country),Washington D.C.

10-NAME OF FATHER,

Joshua Banks11-BIRTHPLACE OF FATHER
(State or Country),Baltimore Co.

12-MAIDEN NAME OF MOTHER

Darah Richardson13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. H. Beck(Address) 2402 N. Charles St.

15-

JUN 17 1915HEALTH DEPARTMENTRegist.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 14, 1915, to June 15, 1915,that I saw him alive on June 14, 1915,and that death occurred, on the date stated above, at 1:02 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach
diagnosed symptomatically and from post-mortem
tumor mass, and X-ray findings.(Duration) one yrs., one mos., ds.CONTRIBUTORY
(Secondary)(Duration) yrs., mos., ds.(Signed) Maurice E. Shannon M. D.June 15, 1915. (Address) 548 N. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Green Mt

DATE OF BURIAL,

June 17, 1915

ADDRESS

North

R. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86100

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86100

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1046 Pennsylvania ave. St. 17 WARD)

2-FULL NAME Charles W. Pitts,

(Residence in Baltimore: No. 1046 Pennsylvania ave.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male,

4-COLOR OR RACE,

Colored,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Single,

6-DATE OF BIRTH,

December 22nd, 1914.
(Month) (Day) (Year)

7-AGE,

0 yrs. 5 mos. 24 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None,

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Charles W. Pitts, sr.

11-BIRTHPLACE OF FATHER

(State or Country),

Virginia,

12-MAIDEN NAME OF MOTHER

Mamie Mason,

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Pitts, mother,

(Address) 1046 Pennsylvania ave.

JUN 17 1915.

Filed....., 191

HARRY O. ANDREWS,

Barial For...
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15th, 1915.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry and that said deceased came to his death (topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia,

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. Frederick Hemper M. D. (Coroner.)

June 15, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

June 17 1915

20-UNDERTAKER

ADDRESS 916

Samuel Capor

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Harford Wm. 14*) WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mrs. Julia Cunningham*(Residence in Baltimore: No. *Aberdeen 110*)

St.; yrs. mos. da)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow*
(Write the word.)

6-DATE OF BIRTH

June 10, 1863
(Month) (Day) (Year)7-AGE, *52* yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.

10-NAME OF FATHER, *E. H. James*11-BIRTHPLACE OF FATHER (State or Country), *MD*12-MAIDEN NAME OF MOTHER, *Julia Cunningham*13-BIRTHPLACE OF MOTHER (State or Country), *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *L. B. Hunt*(Address) *Harford Wm. 14*

15-

JUN 17 1915

HARRY O. ANDREWS,

191 Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 17, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 10 1915, to *June 17* 1915,that I saw him alive on *June 17* 1915,and that death occurred, on the date stated above, at *11:00 am*.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestine

(Duration) yrs. mos. da.

CONTRIBUTORY *Intestinal Obstruction*
(Secondary)

(Duration) yrs. mos. da.

(Signed) *A. P. Jones* M. D.*June 17, 1915* (Address) *Woman's Hospital*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State *5 1/2* yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence *Abingdon MD*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Abingdon MD June 17 1915

20-UNDERTAKER

ADDRESS

W. J. Thompson North Penn

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.: 23

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. - mos. - da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

It LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FULL

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topay or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

In the

of death....yrs.....mos.....da. State....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE—FEMALE. WITH UNFADING INK THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86103

CERTIFICATE OF DEATH

C86103

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

ST. 24 WARD)

2-FULL NAME

(Residence in Baltimore; No.

St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH Dec 13, 1846 (Month) (Day) (Year)

7-AGE 69 yrs. 6 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work None. (b) General nature of industry, business, or establishment in which employed (or employer) House Duties

9-BIRTHPLACE (State or country) N. Y. State

10-NAME OF FATHER Daniel Estline

11-BIRTHPLACE OF FATHER (State or country) U. S. A.

12-MAIDEN NAME OF MOTHER Don't know

13-BIRTHPLACE OF MOTHER (State or country) U. S. A.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. K. Bowers

(Address) 1215 Wm St

JUN 17 1915 HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 15, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1914, to June 15, 1915, that I saw him alive on June 15, 1915, and that death occurred, on the date stated above, at 10:30 p.m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

Contributory (SECONDARY) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Frank C. Fay, M. D. 6/16, 1915 (Address) 1230 S. 6th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt. Olivet Cem June 18, 1915

20-UNDERTAKER ADDRESS

Mrs. Mrs. Jno. N. Luefel 801 N. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUN 17 1915

1915. Serial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

6-5-1915, to 6-16-1915.

that I saw him alive on 6-16-1915.

and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed) O. H. Kaysenbach, M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of deathyrs.mos.ds. In the 33 yrs.mos.ds. State

Where was disease contracted, if not at place of death? Sabillonville Ind.

Former or usual residence 711 S. First St. Highlandtown Md.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL

Sacred Heart Cem.

June 17, 1915.

20-UNDERTAKER

ADDRESS

Lilly & Ziehl

403 S. Wolfe St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86106

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86106

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Josephs Hosp.*)

ST.:

WARD

182
REGISTERED NO. C.

2-FULL NAME

Frank Brzożowski

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1706 Eastern Ave*)

St.: yrs., *2* mos., *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July

1863

(Month) (Day) (Year)

7-AGE,

52

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

Real Estate

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

Adam Brzożowski

11-BIRTHPLACE

OF FATHER
(State or Country),

Germany

12-MAIDEN NAME

OF MOTHER

unknown

13-BIRTHPLACE

OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elizabeth Brzożowski*

(Address) *1706 Eastern Ave*

15-

JUN 17 1915

HARRY O. ANDREWS

101-101 PERMIT OFFICE

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

15

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-

topsy or inquiry.) find that said deceased came to death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY

(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *Eljah Russell*

(Coroner.)

June 17 1915 (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary

June 18 1915

UNDERTAKER

ADDRESS

William Hallows

1618 Eastern Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86107

C86107

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *Masborough Apts.* ST. *14* WARD)

2 FULL NAME *Ida R. Shipley*

(Residence in Baltimore: No. *Masborough Apts.* St.: *life* yrs. *life* mos. *life* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 MARRIAGE *Widowed*
(Write the word)

6 DATE OF BIRTH *Unknown, 1851*
(Month) (Day) (Year)

7 AGE *64* yrs. *64* mos. *64* ds. or *64* min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Balto. Md.*

10 NAME OF FATHER *Jos. C. Meritt*

11 BIRTHPLACE OF FATHER (State or country) *Md.*

12 MAIDEN NAME OF MOTHER *Ross*

13 BIRTHPLACE OF MOTHER (State or country) *Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Jos. C. Shipley*
(Address) *217 St. Paul St.*

15. JUN 17 1915. HARRY O. ANDERSON, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *June 15, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from *Oct 20th*, 1914, to *June 15th*, 1915, that I saw her alive on *June 15th*, 1915, and that death occurred, on the date stated above, at *11 P. m.*

The CAUSE OF DEATH* was as follows:
Malignant Degeneration of a Uterine Fibroma with Metastases
(Duration) *2* yrs. *2* mos. *2* ds.

Contributory (SECONDARY) (Duration) *2* yrs. *2* mos. *2* ds.
(Signed) *William J. Messick* M. D.
June 6, 1915 (Address) *1700 Linden Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *2* yrs. *2* mos. *2* ds. State *2* yrs. *2* mos. *2* ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Green Mount Cemetery* DATE OF BURIAL *June 17, 1915*

20 UNDERTAKER *C. M. Mitchell & Co.* ADDRESS *124 W. Fayette St.*

C86108

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86108

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *812 W. Baltimore St.* ST.; *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *812 W. Baltimore St.* St.; *5* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Widow
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Sept 2, 1880
(Month) (Day) (Year)

7-AGE,

64 yrs. *9* mos. *15* ds.
If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*New York*

10-NAME OF FATHER,

*not known*11-BIRTHPLACE OF FATHER
(State or Country),*not known*

12-MAIDEN NAME OF MOTHER

*not known*13-BIRTHPLACE OF MOTHER
(State or Country),*not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Abbe M. Peilert

(Address)

*812 W. Baltimore St.*15-*JUN 17 1915.**HARRY O. ANDREWS,*

Filed

191

Carla J. Permitt

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 17th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov. 1st 1915 to *June 17th 1915*,that I saw him alive on *June 17th 1915*,and that death occurred, on the date stated above, at *11¹⁵ A.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (Duration) *4* yrs. — mos. — ds.CONTRIBUTORY
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) *Geo. E. Cross* M. D.*June 17th 1915* (Address) *1001 35th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

June 17 1915

20-UNDERTAKER

Joe Block

ADDRESS

1003 7th Balto

N. B.—Every item of information should be carefully supplied. AGE must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86109

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Mary Hospital* ST. *5* WARD)

2-FULL NAME

Samuel Weiss

(Residence in Baltimore: No. *18 N. Eden St.* St.; yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Single
(Write the word.)

6-DATE OF BIRTH,

?

(Month)

(Day)

(Year)

7-AGE,

18

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

City

10-NAME OF FATHER,

Oscar Weiss

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER

(State or Country),

Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Oscar Weiss*

(Address) *18 N. Eden St.*

15-

Filed

JUN 17 1915

ROBERT KRAUTER

BURIAL POTENTIAL CLERK

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June

(Month)

16, 1915

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

Inquest find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide - Revolver wound Head.

(Duration) *1 hr.* yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Thos. B. Chambers* M. D.

June 12 1915 (Address) *18 N. Eden St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *He hasn't the* yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

Refused Mt Carmel

DATE OF BURIAL

June 17, 1915

20-UNDERTAKER

J. Levinson & Bro

ADDRESS

1107 E Balto st

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 W. Lombard ST.) WARD 4

2-FULL NAME

(Residence in Baltimore: No. 402 W. Lombard St.; 6 yrs., 11 mos., 7 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

Married

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

July9th1848

7-AGE,

66 yrs., 11 mos., 7 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Barber

9-BIRTHPLACE,

(State or Country).

Germany

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

Rudolph FortenbaughGermanyTheresa GeigesGermany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. A. Fortenbaugh

(Address)

173 S. Castle St.

15-

JUN 17 1915

ROBERT KRAUTH

BURIAL PERMIT

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June151915

I HEREBY CERTIFY, That I attended deceased from May 3 1915, to June 15 1915, that I saw him alive on June 15 1915, and that death occurred, on the date stated above, at 6 P m. The CAUSE OF DEATH* was as follows:

Voluntary Dissection of Heart

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....

(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

June 16, 1915. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the.....yrs.....mos.....ds. State.....

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Evangelical Lutheran Preb. Ch.June 18, 1915

20-UNDERTAKER

Philip Seewald & Son

ADDRESS

173 S. Castle St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86111

CERTIFICATE OF DEATH.

X 28

C86111

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Md. General Hospital

St.: 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Higgins

(Residence in Baltimore: No.

240 Pine St. Lexington Ky

yrs. 1 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) single

6-DATE OF BIRTH,

Unknown, 1 (Month) (Day) (Year)

7-AGE,

34 yrs.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Horse Dealer

9-BIRTHPLACE, (State or Country),

Unknown

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J.B. wife M.D.

(Address)

150 West Franklin St.

15-

JUN 17 1915

Filed

ROBERT K. KRAUTER

Capital Police Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 16, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 20 1915, to June 16 1915,

that I saw him alive on June 16 1915,

and that death occurred, on the date stated above, at 8:40 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

June 16, 1915 (Address) Md. Gen. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. 1 mos. 26 ds. In the State yrs. ? mos. ? ds.

Where was disease contracted, if not at place of death? Lexington Ky.

Former or usual residence Lexington Ky.

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cem. June 17, 1915

20-UNDERTAKER

W. J. Tedman & Sons Cedar Hill, Ky.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86112

CERTIFICATE OF DEATH

REGISTERED NO. C. 144

1-PLACE OF DEATH

Hebrew Hospital

CITY OF BALTIMORE: (No. 8)

East Monument

ST. 6

WARD

2-FULL NAME

Adam Link

(Residence in Baltimore: No. 2317

Jefferson St

St. 57 yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Feb

10

1958

7-AGE

57

4

mos.

5

ds.

or

min.?

IF LESS than

1 day, hrs.

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Clothing

Tailor

9-BIRTHPLACE

(State or country)

Md

10-NAME OF FATHER

Henry Link Sr

11-BIRTHPLACE OF FATHER

(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Catherine Krause

13-BIRTHPLACE OF MOTHER

(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ellen Link

(Address)

2317 E. Jefferson St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

15

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 14, 1915, to, June 15, 1915,

that I saw him alive on June 15, 1915,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

abscess of thigh (left)

(Duration) yrs. 1 mos. 3 weeks

Contributory (SECONDARY)

(Duration) yrs. 1 mos. 3 weeks

(Signed), M. B. Levine M. D.

June 15, 1915 [Address] Hebrew Hosp

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. 1 mos. 1 ds. In the 57 yrs. 1 mos. 1 ds.

Where was disease contracted, If not at place of death? 2317 Jefferson St

Former or usual residence 2317 Jefferson St

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Cemetery

June 18/1915

20-UNDERTAKER

ADDRESS

Christian Miller

235 E. Jefferson St

18-

ROBERT KRAUTER

JUN 17 1915

Burial Permit

REGISTRAR

C86113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 C86113
REGISTERED NO. C

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 Hubbard Alley ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME

(Residence in Baltimore: No. 933 Hubbard Alley

St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX.

male

4. COLOR OR RACE.

colored

5. SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
single

6. DATE OF BIRTH,

Unknown; 1
(Month) (Day) (Year)

7. AGE,

17 yrs. mos. da.

If LESS than 1 day.

...hrs. or ...min.

8. OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9. BIRTHPLACE,
(State or Country),

va

10. NAME OF FATHER,

Geo. Hundell

11. BIRTHPLACE OF FATHER
(State or Country),

va

12. MAIDEN NAME OF MOTHER

Anne — Hundell

13. BIRTHPLACE OF MOTHER
(State or Country),

va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Officer Crowder(Address) 933 Hubbard Alley

15.

JUN 17 1915. ROBERT KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH,

June 15, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1915 to June 15 1915, that I saw him alive on June 14 1915, and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

1 year (Duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)Dysentery (Heart failure)
months (Duration) yrs. mos. da.

(Signed) J. Edward Fisher, M. D.

June 16, 1915. (Address) 1112 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL,

Land C

DATE OF BURIAL,

June 17, 1915

20. UNDERTAKER

Roth & Elliott 506 East St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *16* WARD)

2-FULL NAME *Alfred Wilson*

(Residence in Baltimore: No. *1129 Whatcoat St.* St.; yrs. mos. ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and NH out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male*

4-COLOR OR RACE *negro*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *married*

6-DATE OF BIRTH *Feb 15 1879*

(Month)

(Day)

(Year)

7-AGE *36* yrs. — mos. — ds. or min.?

If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9-BIRTHPLACE (State or country) *md.*

10-NAME OF FATHER *Alfred Wilson*

11-BIRTHPLACE OF FATHER (State or country) *Va.*

12-MAIDEN NAME OF MOTHER *Virginia Hegler*

13-BIRTHPLACE OF MOTHER (State or country) *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. H. Hoff*

(Address)

15-*JUN 17 1915* ROBERT KRAUTER, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 15 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 29*, 1915, to *June 15*, 1915,

that I saw him alive on *June 15*, 1915,

and that death occurred, on the date stated above, at *8:45 p.m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contributory (SECONDARY) *Acute myelogenous leukemia*

(Signed) *Stanhope Bayne-Jones* M. D.
June 15, 1915 [Address] *Johns Hopkins*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *36* ds. *17*

Where was disease contracted, if not at place of death?

Former or usual residence *1129 Whatcoat St.*

19-PLACE OF BURIAL OR REMOVAL *St. Luke's*

DATE OF BURIAL *June 17*, 1915

20-UNDERTAKER *Sam'l. H. Lee*

ADDRESS *440 Mosher*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 William St.

ST.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Hall

(Residence in Baltimore: No. 1430 William St.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
widower

6-DATE OF BIRTH,

Sept 30 1891

June

(Month)

(Day)

15

(Year)

7-AGE,

83 yrs. 8 mos. 16 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Snow hill Md

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margie A. Jero's(Address) 1430 William St.

15-

Filed

JUN 18 1915

HARRY C. ANDREWS,

TAYLOR FORBES, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 16, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15th 1915, to June 16 1915,

that I saw him alive on June 15 1915,

and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) about 1 year yrs. mos. ds.

CONTRIBUTORY Heat Exhaustion

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Philip B. Towle M. D.6/17, 1915. (Address) 1432 William St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

MOUNT OLIVET

JUN 18 1915

20-UNDERTAKER

ADDRESS

ARMSTRONG-DENNY CO.

715 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86116

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86116

CERTIFICATE OF DEATH.

PLACE OF DEATH *St. Josephs Hospital 3*
CITY OF BALTIMORE (No. *3*) WARD
*FULL NAME *Catherine Cirelli*
(Residence in Baltimore: No. *718 Duker Alley*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *2* yrs. *5* mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *S.*
6-DATE OF BIRTH, *January 12th, 1913*
(Month) (Day) (Year)
7-AGE, *2* yrs. *5* mos. *4* ds. IF LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Balt & Md.*

10-NAME OF FATHER, *Chas. Cirelli*

11-BIRTHPLACE OF FATHER (State or Country), *Italy*

12-MAIDEN NAME OF MOTHER *Emma Mattrotti*

13-BIRTHPLACE OF MOTHER (State or Country), *Balt. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Chas. Cirelli*
(Address) *718 Duker Alley*

15-*JUN 18 1915* HARRY O. ANDREWS,
Filed, 191*5* Special Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 16th, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

THE CAUSE OF DEATH was as follows:
Fracture of base of skull and comp. fracture of lower maxilla accidentally with over by a wagon.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Wm. M. Savage* M. D. (Coroner.)
June 17th, 1915 (Address) *1729 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the *2* yrs. *5* mos. *4* ds.

Where was disease contracted, if not at place of death? *On Eastern Ave. between 22nd & 23rd Sts.*
Former or usual residence *718 Duker Alley*

19-PLACE OF BURIAL OR REMOVAL, *St. Vincent's Cem.* DATE OF BURIAL, *June 18 1915*

20-UNDERTAKER *Wendell Lippel & Son* ADDRESS *37 S. Union St*
(Over)

C86117

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86117

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Aliceanna ST.; 2 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1615 Aliceanna

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 9 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Single
MARRIED
WIDOWED
OR RECORDED
(Write the word.)6-DATE OF BIRTH, Sept. 4, 1914
(Month) (Day) (Year)7-AGE, 9 yrs. 14 mos. 14 ds. IF LESS than 1 day,
...hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant9-BIRTHPLACE, (State or Country) Baltimore10-NAME OF FATHER, John Wodka11-BIRTHPLACE OF FATHER (State or Country) Russian Poland12-MAIDEN NAME OF MOTHER Annie Klimetz13-BIRTHPLACE OF MOTHER (State or Country) Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Wodka(Address) 1615 Aliceanna St15- JUN 18 1915 HARRY O. ANGLERFiled..... 191. Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 17, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 2 1915, to June 17 1915, that I saw him alive on June 16 1915, and that death occurred, on the date stated above, at 7:30 A. m. The CAUSE OF DEATH* was as follows:Enteritis & enterocolitis of ileocolon & malnutrition(Duration)..... yrs. 1 mos. 1 ds.CONTRIBUTORY Malnutrition & enteritis
(Secondary)(Duration)..... yrs. 1 mos. 1 ds.(Signed) Thos. A. Rutledge M. D.
June 18, 1915. (Address) 1106 Jackson Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary DATE OF BURIAL, June 18, 1915.20-UNDERTAKER William T. Gialowski ADDRESS 1618 EasternAve.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.; 4 WARD)

2-FULL NAME

Residence in Baltimore: No.

St.: Life yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed.

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on, and that death occurred, on the date stated above, at 10:45 P.M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY

(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. In the State.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2549 W Fairmount Ave* ST. *70* WARD)2-FULL NAME *John Eugene Late*Residence in Baltimore: No. *2549 W Fairmount Ave* ST. *70* yrs. *35* mos. *35* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH *Feb 20 1880*

(Month)

(Day)

(Year)

7-AGE *35* yrs. *3* mos. *26* ds.If LESS than 1 day,
...hrs. or....min.?8-OCCUPATION: *Insurance collector*(a) Trade, profession, or particular
kind of work.....(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....9-BIRTHPLACE,
(State or Country), *MD*

PARENTS.

10-NAME OF
FATHER, *Wm E Late*11-BIRTHPLACE
OF FATHER
(State or Country), *MD*12-MAIDEN NAME
OF MOTHER *Maudie E Derr*13-BIRTHPLACE
OF MOTHER
(State or Country), *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. Late*(Address) *2549 W Fairmount Ave*

15-

Filed *JUN 18 1915*

191...

Serial *101*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 15 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from
June 9 1915, to *June 15 1915*,
that I saw him alive on *June 14 1915*,
and that death occurred, on the date stated above, at *8 PM* m.

The CAUSE OF DEATH* was as follows:

*Tuberculosis of
prostate gland*(Duration) *12* yrs. *12* mos. *12* ds.CONTRIBUTORY
(Secondary) *Hemorrhage**Exhaustion* (Duration) *6* yrs. *6* mos. *6* ds.(Signed) *John E. Late* M. D.*Capit.* 1915. (Address) *1814 Light St**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *35* yrs. *35* mos. *35* ds. In the State *35* yrs. *35* mos. *35* ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL, *June 18 1915*20-UNDERTAKER *John E. Late*ADDRESS *1814 Light St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86122

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

C86122

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 24 WARD)

2-FULL NAME

(Residence in Baltimore: No.

Sr.: 40 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6-DATE OF BIRTH July 11, 1875 (Month) (Day) (Year)

7-AGE 69 yrs. 11 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Germany

10-NAME OF FATHER Eberhart H. Bode

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Marie Teirsee

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Kate May

(Address) 705 E. Fort Ave.

15- JUN 18 1915 HARRY O. ALLEN, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 16, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 20, 1915, to June 16, 1915, that I saw her alive on June 15, 1915, and that death occurred, on the date stated above, at 1 a.m. The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

Contributory (SECONDARY) Rheumatism. (Duration) 1 yrs. 1 mos. ds. (Signed) Wm. T. Seabury M. D. June 17, 1915 (Address) 621 E. Fort Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Balto. Cemetery DATE OF BURIAL June 18, 1915

20-UNDERTAKER W. J. M. Flynn ADDRESS 1422 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86123

CERTIFICATE OF DEATH

79 C86123
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1)

FULL NAME

Residence in Baltimore: No.

740 George St. 17 WARD
Nancy Wilson
740 George St. 60 yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6 DATE OF BIRTH Unknown, 1 (Month) (Day) (Year)

7 AGE 64 yrs. — mos. — ds. If LESS than 1 day, — hrs. or — min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Stone (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ireland

10 NAME OF FATHER Matthew Wilson

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rebecca J. Monahan

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anne J. Wilson

(Address) 740 George St.

15 JUN 19 1915 ROBERT KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 16, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from abt. March 18, 1915, to June 16, 1915, that I saw her alive on June 14, 1915, and that death occurred, on the date stated above, at 6 P. M. The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart (Duration) abt. 3 yrs. — mos. — ds.

Contributory (SECONDARY) (Duration) yrs. — mos. — ds.

(Signed) W. B. Rider M. D. June 18, 1915 (Address) 567 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL June 19, 1915

20 UNDERTAKER Geo. W. Little ADDRESS 531 Fremont Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1318 Greenmount Ave* ST. *12* WARD)

REGISTERED NO. C

2-FULL NAME

Samuel P Wilson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1318 Greenmount Ave*

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *married*

6-DATE OF BIRTH,

June 17, 1844
(Month) (Day) (Year)

7-AGE,

73-11 mos. 30 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Bridges Harbor.*

9-BIRTHPLACE, (State or Country),

Maryland.

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Minnie Wilson*(Address) *1318 Greenmount Ave.*

15-

JUN 19 1915

ROBERT

KRAUTER,

Filed

101. *Carroll Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1915, to *June 16, 1915*,that I saw him alive on *June 15, 1915*,and that death occurred, on the date stated above, at *11:30 p.m.*

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) *1* yrs. mos. ds.CONTRIBUTORY (Secondary) *arteriosclerosis*(Duration) *3* yrs. mos. ds.(Signed) *Wm. Pearson* M. D.*June 18, 1915* (Address) *J. E. Pearson*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*London Box Cemetery**June 20, 1915*

20-UNDERTAKER

ADDRESS

H. E. Hughes 17 S. 17th St.

N. B. Every item of information should be carefully copied. The statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 C86125

1. PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 2210 W. North Ave. ST. 15 WARD)

2. FULL NAME Simon C. Rosenberg

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2210 W. North Ave. St. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widower

6. DATE OF BIRTH

June 15, 1839
(Month) (Day) (Year)

7. AGE

76 yrs.

3 mos.

 ds.

If LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired Merchant

9. BIRTHPLACE

(State or country)

Germany

10. NAME OF FATHER

Herman Rosenberg

11. BIRTHPLACE OF FATHER
(State or country)

Germany

12. MAIDEN NAME OF MOTHER

Bertha Rosenberg

13. BIRTHPLACE OF MOTHER
(State or country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. B. L. Cotton

(Address)

2210 W. North Ave.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 18, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from

June 12, 1915 to June 18, 1915
that I saw him alive on June 17, 1915
and that death occurred, on the date stated above, at 3:40 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Emphysema

Contributory (SECONDARY)

(Duration) yrs. mos. 5 ds.

Dilated Heart

(Duration) yrs. mos. 3 ds.

(Signed) R. C. Mehel M. D.

June 18, 1915 (Address) 1903 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Balto Helix

DATE OF BURIAL

June 20, 1915

20. UNDERTAKER

Ward Sondheim

ADDRESS

1122 W. North Ave.

JUN 19 1915

Filed , 191

ROBERT KRAUTER,
Sanial Permit Clerk

REGISTRAR

C86126

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 C86126

CERTIFICATE OF DEATH.

PLACE OF DEATH *Hahnemann Gen Hospital*

REGISTERED NO. C

CITY OF BALTIMORE: (No. *1142 N Mount* ST.; *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Miss Laura Wood*(Residence in Baltimore: No. *765 Lexington* St.; *1* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *Single*
MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *Unknown*, *1* (Month) (Day) (Year)7-AGE, *53* yrs., *—* mos., *—* ds. If LESS than 1 day, *—* hrs. or *—* min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Unknown*
(b) General nature of industry, business, or establishment in which employed (or employer), *Unknown*9-BIRTHPLACE, (State or Country), *Virginia*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs R G Bourne*(Address) *Frederick St. W. 24*15- *JUN 19 1915* *ROBERT KRAUTER*Filed *Surina Permit 91* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 17*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 23* 1915, to *June 17* 1915, that I saw her alive on *June 17* 1915, and that death occurred, on the date stated above, at *9:10* P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) *—* yrs., *3* mos., *5* ds.CONTRIBUTORY *Liban Pneumonia*
(Secondary)(Duration) *—* yrs., *5* mos., *—* ds.(Signed) *Wm Dew* M. D.*June 17, 1915* (Address) *Hahnemann Gen Hospital 1122 N Mount St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs., *25* mos., *—* ds. In the *1* yrs., *—* mos., *—* ds. StateWhere was disease contracted, if not at place of death? *Unknown*Former or usual residence *Hedges, Nebraska*19-PLACE OF BURIAL OR REMOVAL, *Frederick St. W. 24*DATE OF BURIAL, *June 18, 1915*20-UNDERTAKER *Wm Wontz*ADDRESS *230 Mermaid*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86127

CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 558 McMechen St.: 14 WARD)
2-FULL NAME James S. Russell
(Residence in Baltimore: No. 558 McMechen St.; 40 yrs. 0 mos. 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and full lot No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE white 5-SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
6-DATE OF BIRTH June 17, 1861
(Month) (Day) (Year)
7-AGE 54 yrs. 0 mos. 0 ds. or 1 day 0 hrs. 0 min.?
8-OCCUPATION
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Flour.

9-BIRTHPLACE (State or country) Queen Anne's Co Md

PARENTS
10-NAME OF FATHER Thos Russell
11-BIRTHPLACE OF FATHER (State or country) Scotland
12-MAIDEN NAME OF MOTHER Mary E. Steele
13-BIRTHPLACE OF MOTHER (State or country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mary A. Russell
558 McMechen St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 17, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1915, to, June 17, 1915, that I saw him alive on June 16, 1915, and that death occurred, on the date stated above, at 2:30 m. The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. mos. 20 ds.
Contributory (SECONDARY) Lobar pneumonia

(Duration) yrs. mos. 7 ds.
(Signed), Geo. T. Kemp M. D.
June 18, 1915 [Address] St James Apartment

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

London Park Cemetery June 19, 1915

20-UNDERTAKER ADDRESS 1944

Harry W. Ehlert W. North

15-JUN 19 1915 ROBERT KRAUTER
REGISTRAR

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1. PLACE OF DEATH
CITY OF BALTIMORE (No. *217 Amity St* ST. *18* WARD)
2. FULL NAME *Mrs Frederick Reitzel*
(Residence in Baltimore: No. *217 Amity St* St. *70* yrs. *4* mos. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. ~~SINGLE~~ ~~MARRIED~~ ~~WIDOWED~~ ~~DIVORCED~~ *Widow*
(Write the word)
6. DATE OF BIRTH *July 10*, 18*27*
(Month) (Day) (Year)
7. AGE *87* yrs. *11* mos. *7* ds. or min.?
If LESS than 1 day, hrs.
8. OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) *Housewife*
9. BIRTHPLACE (State or country) *Germany*
10. NAME OF FATHER *Charles Fraski*
11. BIRTHPLACE OF FATHER (State or country) *Germany*
12. MAIDEN NAME OF MOTHER *Unknown*
13. BIRTHPLACE OF MOTHER (State or country) *Germany*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Frederick Reitzel*
(Address) *217 Amity St*

15. *JUN 19 1915* *ROBERT KRAUTER,*
Barista Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *June 17*, 191*5*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan 15*, 191*5*, to *June 17*, 191*5*,
that I saw her alive on *June 16*, 191*5*,
and that death occurred on the date stated above, at *4 P* m.

The CAUSE OF DEATH* was as follows:
Chronic Intestinal
Nephritis
(Senile dementia)

(Duration) *3* yrs. *11* mos. *7* ds.
Contributory *Acute dilatations*
(SECONDARY) *of heart*
(Duration) *7* yrs. *11* mos. *7* ds.

(Signed) *Chas. A. Fietterhoff, M.D.*
June 17, 191*5* (Address) *1807 20th Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *70* yrs. *4* mos. *7* ds. In the State *70* yrs. *4* mos. *7* ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *St Pauls Luth Amity* DATE OF BURIAL *June 20*, 191*5*

20. UNDERTAKER *Mrs A Robinson* ADDRESS *730 Pa Ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86129

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2578 Francis*)

2-FULL NAME

Catherine Eliz. Schultheis

(Residence in Baltimore: No. *2508 Francis*)

REGISTERED NO. C

ST. *13* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

married

6-DATE OF BIRTH

Jan 5, 1858
(Month) (Day) (Year)

7-AGE

57 yrs. *5* mos. *11* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

House-wife

9-BIRTHPLACE (State or country)

Balto City

10-NAME OF FATHER

Daniel Swartz

11-BIRTHPLACE OF FATHER (State or country)

Germany

12-MAIDEN NAME OF MOTHER

Elizabeth Snaker

13-BIRTHPLACE OF MOTHER (State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dora Schultheis

(Address)

2508 Francis St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY. That I attended deceased from

May 5, 1915, to June 16, 1915.

that I saw h. alive on *June 14, 1915.*

and that death occurred, on the date stated above, at *8:30 P. m.*

The CAUSE OF DEATH* was as follows:

Acute Rheumatism

about (Duration) *2* yrs. *2* mos. *2* ds.

Contributory *Cerebral Rheumatism* (SECONDARY)

(Duration) *1* yrs. *1* mos. *1* ds.

(Signed) *Chas. C. Conser* M. D.

June 17, 1915 (Address) *1101 N. Fulton Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *1* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St Paul's Luth Cemetery

DATE OF BURIAL

June 19, 1915

20-UNDERTAKER

Mrs. A. Rohde Sen

ADDRESS

730 Pa Ave

JUN 19 1915

Filed *1915*

ROBERT KRAUTER

Bureau Permit Clerk

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86130

CERTIFICATE OF DEATH

C86130

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

79
18
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Dec. 11, 1832
(Month) (Day) (Year)

7 AGE 82 yrs. 7 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION none
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Virginia U.S.A

10 NAME OF FATHER John A. Gere

11 BIRTHPLACE OF FATHER (State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Sarah Neal

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carrie C. Thomas

(Address) 407 N. Carey St

15 JUN 19 1915 ROBERT . KRAUTER,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 18, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1915 to June 18, 1915 that I saw her alive on June 18, 1915 and that death occurred, on the date stated above, at 3 a. m. The CAUSE OF DEATH* was as follows:

Chronic myocarditis

not known (Duration) yrs. mos. ds.

Contributory (SECONDARY) Indefinite (Duration) yrs. mos. ds.

(Signed), H. H. Arthur M. D. (Address) 1426 W. Kanawha St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Oliver Cemetery DATE OF BURIAL 6/21, 1915

20 UNDERTAKER Geo. J. Smith ADDRESS 1000 W. Fairview St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Sarah Ann

ST.: 18 WARD)

REGISTERED NO. C

2-FULL NAME Mary Elizabeth Blake

(Residence in Baltimore: No. 902 Sarah Ann St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

colored

5-SINGLE,

MARRIED, married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

October 22, 1871
(Month) (Day) (Year)

7-AGE,

43 yrs. 8 mos. 26 ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Cook (Cook)

9-BIRTHPLACE,

(State or Country),

Baltimore Ind.

10-NAME OF FATHER,

John Thomas

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland.

12-MAIDEN NAME OF MOTHER

Mary (unknown)

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chester Peland, M.D.

(Address) 2532 Edmondson Ave

15-

JUN 19 1915

HARRY O. ANDREWS,

Filed

191. Serial Permit. Olex

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 17, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14, 1915, to June 17, 1915, that I saw her alive on June 17, 1915, and that death occurred, on the date stated above, at 8:15 P.m.

The CAUSE OF DEATH* was as follows:

lobar pneumonia

(Duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Chester Peland M. D.

6-18-1915 (Address) 2532 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Auburn cemetery

June 19, 1915

20-UNDERTAKER

ADDRESS

Walter Owens

235 Pine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86132

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86132

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-~~SINGLE~~

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

IF LESS than

1 day, --- hrs.

or --- min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

JUN 19 1915

HARRY O. ANDERSON

Married Permit 0101

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month)

(Day)

(Year)

I HEREBY CERTIFY That I attended deceased from

May 1, 1915, to June 17, 1915,

that I saw him alive on June 17, 1915,

and that death occurred, on the date stated above, at 5:00 m.

The CAUSE OF DEATH* was as follows:

pericarditis

Contributory

(SECONDARY)

(Signed)

J. A. Fellnerhoff

June 17, 1915

(Address)

2042 E. Fairview

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park

June 17, 1915

20-UNDERTAKER

ADDRESS

Kirkman Gore

1713 N. Lafayette

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH
CITY OF BALTIMORE: (No. 1559 N. Gilman ST. 15 WARD) REGISTERED NO. C.
2-FULL NAME Hannie Drees
(Residence in Baltimore: No. 1559 N. Gilman St St.; Life Insurance.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow
6-DATE OF BIRTH July 22, 1901
(Month) (Day) (Year)
7-AGE 13 yrs. 10 mos. 16 ds. If LESS than 1 day, hrs. min.?
8-OCCUPATION (a) Trade, profession or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER Hann Drees
11-BIRTHPLACE OF FATHER Baltimore Md
12-MAIDEN NAME OF MOTHER Anna E. Drees
13-BIRTHPLACE OF MOTHER Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hann Drees
(Address) 1559 N. Gilman St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 16, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1915, to June 16, 1915, that I saw him alive on June 5, 1915, and that death occurred, on the date stated above, at 9:45 a.m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contributory (SECONDARY) By Heart
Same March 22, 1915 (Duration) yrs. mos. ds.

(Signed) June 15, 1915 [Address] NT. 2nd St. Baltimore M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Western Cem June 19, 1915
20-UNDERTAKER Wm J. Glickner ADDRESS North & Pa

19 JUN 19 1915
Filed 191 HARRY O. ANDREWS, REGISTRAR

C86134

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

529 N. Fulton Ave. 19

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William James Watts

(Residence in Baltimore: No.

529 N. Fulton Ave

St.; 40 yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

March

14

1852

(Month)

(Day)

(Year)

7-AGE,

63

3

13

If LESS than 1 day.

yrs. 3 mos. 13 ds.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Pensioned

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer United Railways

9-BIRTHPLACE, (State or Country).

Anne Arundel Co. Md

10-NAME OF FATHER,

Samuel Watts

11-BIRTHPLACE OF FATHER, (State or Country).

Md

12-MAIDEN NAME OF MOTHER

Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country).

Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Trine Watts

(Address)

529 N. Fulton Ave

15-

Filed

JUN 19 1915

HARRY O. ANDREWS,

Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

17

1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 30, 1912, to

June 17, 1915

that I saw him alive on

June 16, 1915

and that death occurred, on the date stated above, at 7:10 P.M.

The CAUSE OF DEATH* was as follows:

Rheumatism Chronic

CONTRIBUTORY (Secondary)

(Duration) 3 yrs. 6 mos. 13 ds.

Pericarditis

(Signed) Geo. C. Shannon M. D.

June 17, 1915 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Odenton Md

June 20, 1915

20-UNDERTAKER

ADDRESS

Geo. Weber & Son 2503 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 C86135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 Wellington Ave 13 WARD)

2-FULL NAME Sarah A. Meade

(Residence in Baltimore: No. 806 Wellington Ave St. 30 yrs. mos. ds.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and BU cert No. 1B.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

5-SINGLE MARRIED Married

6-DATE OF BIRTH Oct 22, 1858

7-AGE 56 7 26

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

PARENTS

10-NAME OF FATHER Thomas Ryan

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER Isabella Wright

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 18, 1915

17-I HEREBY CERTIFY, That I attended deceased from Oct 1, 1914, to June 18, 1915,

that I saw him alive on June 17, 1915, and that death occurred, on the date stated above, at 4:40 m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis
(See remarks below)

Contributory (SECONDARY) Exacerbation of condition

(Signed) R. B. Norman M. D.
19, 1915 [Address] 3347 Chestnut St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20-UNDERTAKER ADDRESS

JUN 19 1915

HARRY O. ARUNDEL

SERIAL FORM 10 101

REGISTRAR

St Marys, June 25, 1915
A. S. Marshall 3339 Talbot Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *1327 Myrtle Av.* ST.; *17* WARD).

(If death occurred in a hospital or institution, give its NAME instead of street and number and full No. 18.)

2-FULL NAME *Mary Horrigan (Horrigan)*(Residence in Baltimore: No. *1327 Myrtle Ave.* St.; *50* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 19 1915

Baltimore City Health Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 18th, 191*5*.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 3rd 1909*, to *June 18th 1915*, that I saw him alive on *June 17th 1915*, and that death occurred, on the date stated above, at *8 a. m.*

The CAUSE OF DEATH* was as follows:

*Arterio Sclerosis,
Apoplexy & Paralysis
with their complications*(Duration) *6* yrs. *5* mos. *15* ds.CONTRIBUTORY
(Secondary)*Emul. Drops, Heart fail
ure & Spasm* (Duration) *about 6 mos*(Signed) *Silas Balmain* M. D.*June 19, 1915.* (Address) *707 W. 2nd St. av*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral *June 24, 1915.*

20-UNDERTAKER

ADDRESS

M. Fahay & Sons 606 Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.*)ST. *14* WARDREGISTERED NO. C *86137*

2-FULL NAME

Josephine Crowder

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; *1* yrs, *4* mos. *24* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Female</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>Single</i> (Write the word.)
-------------------------	----------------------------------	--

6-DATE OF BIRTH,

January 24th, 1914
(Month) (Day) (Year)

7-AGE,

1 yrs. *4* mos. *24* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUN 19 1915 HARRY ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 17th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 15th 1915* to *June 16th 1915*, that I saw her alive on *June 16th 1915*, and that death occurred, on the date stated above, at *12.30* p.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteric intoxication(Duration) ... yrs. ... mos. *2* ds.CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Elmer G. Hall* M. D.191... (Address) *1678 North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *4* mos. *24* ds. In the State *1* yrs. *4* mos. *24* ds.Where was disease contracted, if not at place of death? *St. Vincent's Infant Asylum*Former or usual residence *St. Vincent's Infant Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral June 19, 1915

20-UNDERTAKER

ADDRESS

M. Faher & Sons 606 Lafayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86138

C86138

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hosp* 126
 CITY OF BALTIMORE: (No. *London & Greene* ST.; 27 WARD)
 2-FULL NAME *Jeremiah Brashears*
 (Residence in Baltimore: No. *42 E. York* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
 (Write the word.)
 6-DATE OF BIRTH, *1842*
 (Month) (Day) (Year)
 7-AGE. *73* yrs. mos. ds. If LESS than 1 day, hrs. or min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Carrage Painter*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). *MD*
 10-NAME OF FATHER. *Frank Brashears*
 11-BIRTHPLACE OF FATHER (State or Country). *MD*
 12-MAIDEN NAME OF MOTHER. *Rebecca Hatten*
 13-BIRTHPLACE OF MOTHER (State or Country). *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *Deceased*
 (Address) *42 E York St*

15- *JUN 19 1915* HARRY O. ANDREWS, Jr.
 Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *6-15-1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *5-31-1915* to *6-15-1915*, that I saw him live on *6-15-1915*, and that death occurred, on the date stated above, at *50* m. The CAUSE OF DEATH* was as follows:

Edema of Lungs & Uremia
 (Duration) yrs. mos. ds. *1*
 CONTRIBUTORY (Secondary) *Hypertension*
 (Duration) yrs. mos. ds. *1*
 (Signed) *M. E. McIntosh, M. D.*
6-15-1915 (Address) *University Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
 At place of death yrs. mos. ds. *16* In the *73* yrs. mos. ds.

Where was disease contracted, if not at place of death? *Former*
 Former or usual residence *42 E York St*

19-PLACE OF BURIAL OR REMOVAL. HOPKINS HOSPITAL. DATE OF BURIAL. *JUN 18 1915*
 20-UNDERTAKER. *Commissioner of Health* ADDRESS

FOR ANATOMICAL PURPOSES.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86139

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86139

CERTIFICATE OF DEATH

1 PLACE OF DEATH

Bridle & Sellman Sanatorium

REGISTERED NO. C

CITY OF BALTIMORE: (No.

2724, Charles St.

WARD

15

2-FULL NAME

Katherine M. Waller

(Residence in Baltimore: No.

* 1611 N. Fulton Ave.

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

Not known

(Month)

(Day)

(Year)

7-AGE

32

yrs.

mos.

ds.

or

min.

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

Maine

10-NAME OF FATHER

Not known

11-BIRTHPLACE OF FATHER
(State or country)

Not known

12-MAIDEN NAME OF MOTHER

Mary Foss

13-BIRTHPLACE OF MOTHER
(State or country)

Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alva. Heat.

(Address)

* 809 N. Fulton Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

16

1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

11th June, 1915, to, 16th June, 1915,

that I saw her alive on 16th June, 1915,

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Pelvic Peritonitis
developed after operation for removal
of pelvis + ovary which was diagnosed
(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

June 16, 1915. [Address] 117 N. Saratoga

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place

of death

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Oak Lawn

DATE OF BURIAL

June 19, 1915

20-UNDERTAKER

E + B Harle.

ADDRESS

115 E. West St.

JUN 19 1915

HARRY O. ANGLER

Marital Permit Clerk.

REGISTRAR

C86140

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86140

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Died at Sellman Lane

REGISTERED NO. C

2-OF BALTIMORE: (No.

777 1/2 N. Charles ST.; 17

WARD)

2-FULL NAME

Baby of Leslie Grace Richardson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

Haltorpe Md

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH,

June 18, 1915

(Month)

(Day)

(Year)

7-AGE,

If LESS than 1 day,

yrs. mos. ds.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Baltimore Md

10-NAME OF FATHER,

Leslie Richardson

11-BIRTHPLACE OF FATHER
(State or Country),

Havana Co Md

12-MAIDEN NAME OF MOTHER

Grace Horn

13-BIRTHPLACE OF MOTHER
(State or Country),

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Leslie Richardson

(Address)

Haltorpe Md

15-JUN 19 1915

HARRY O. ANDREWS,

Filed.....

1915. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 18, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 14 1915, June 18 1915,

that I saw him alive on June 18 1915,

and that death occurred, on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY Acute Nephritis

(Duration) yrs. mos. ds.

(Signed) D. A. Schultz M. D.

191... (Address) Groversville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Linden Park Cemetery

June 17, 1915

20-UNDERTAKER

ADDRESS

Joseph B. Cook

1003 N. Calhoun

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86141

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2915 Guilford Ave.* St. *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore No. *2915 Guilford Ave.* St. *47* yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Mar 27, 18*88*
(Month) (Day) (Year)

7-AGE,

47 yrs. *2* mos. *22* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Artist*(b) General nature of industry, business, or establishment in which employed (or employer) *Latrobe Pa*

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anna W. Naulty*(Address) *2915 Guilford Ave.*

15-

JUN 19 1915

HARRY O. ANDREWS,

Filed *1915* *10-1* Permit *Clark*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 18, 19*15*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 4 19*15*, to *June 18* 19*15*,that I saw him alive on *June 18* 19*15*,and that death occurred, on the date stated above, at *10 P* m.

The CAUSE OF DEATH* was as follows:

*Chronic Bright's Disease**(Duration) 2 yrs. mos. ds.*

CONTRIBUTORY (Secondary)

Edema of Lungs(Signed) *E. M. Williams* M. D.*June 18, 1915* (Address) *127 1/2 North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral Cemetery *June 21*, 19*15*.

20-UNDERTAKER

Henry H. Jenkins & Sons Co. Richard, Sts.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86142

CERTIFICATE OF DEATH.

REGISTERED NO. C.

PLACE OF DEATH

CITY OF BALTIMORE (No. 23 E Hill St

ST. 22 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME James Albert Eckerle

(Residence in Baltimore: No. 23 E Hill St

St. 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

55

YRS.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country),

Boston Mass

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma m Watson

(Address) Catonville Balto. Co. Md.

15-

JUN 19 1915

HARRY O. ANDREWS,

Filed. 191. Serial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

13

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

Inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

inquiry

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Edw. G. Smith

(Coroner.)

M. D.

June 16 1915 (Address) 517 Scott St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill

June 24 1915

20-UNDERTAKER

ADDRESS 916

Samuel Easton

Baltimore

C86143

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86143

CERTIFICATE OF DEATH

150-151

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 104 W. 26th St. 12 WARD)

2-FULL NAME Infant son of Harry & Elizabeth Baker

(Residence in Baltimore: No. 104 W. 26th St. (at thirty minutes) yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE

6-DATE OF BIRTH June 19 1915 (Month) (Day) (Year)

7-AGE Thirty minutes If LESS than 1 day, 2 mos. or 3 yrs.

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Balto City

PARENTS 10-NAME OF FATHER Harry Baker 11-BIRTHPLACE OF FATHER (State or country) Balto City 12-MAIDEN NAME OF MOTHER Elizabeth Smith 13-BIRTHPLACE OF MOTHER (State or country) Carroll County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Baker (Address) 104 W. 26th

15- JUN 19 1915 HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 19 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased at Baltimore 1915, to, June 19 1915, that I saw him alive on June 19 1915, and that death occurred, on the date stated above, at 4:50 am. The CAUSE OF DEATH* was as follows:

Defective intrauterine development of heart & birth in sixth month of gestation (Duration) yrs. mos. ds. 20 mo.

Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) J. H. Kelly M. D. June 19 1915 [Address] 3845 1/2 Beland St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Marys Hospital June 19 1915

20-UNDERTAKER ADDRESS

McGosson 700 W 31st St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86144

C86144

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.*)

2-FULL NAME

(Residence in Baltimore: No. *1219 Roanoke St. Roanoke, Va.*)

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-~~Married~~
MARRIED,
WIDOWED,
OR ~~Divorced~~
(Write the word.)

6-DATE OF BIRTH

September 2, 1872
(Month) (Day) (Year)

7-AGE.

*42 yrs. 9 mos. 17 ds.*If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*9-BIRTHPLACE,
(State or Country).*Va.*

10-NAME OF FATHER,

*Henry Kellogg*11-BIRTHPLACE OF FATHER
(State or Country).*Vt.*

12-MAIDEN NAME OF MOTHER

*Mary Staples*13-BIRTHPLACE OF MOTHER
(State or Country).*Va.*14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *J. S. Shields*
(Address) *Johns Hopkins Hosp.*15-
Filed *JUN 19 1915* *HARRY O. ANDREWS*
Burial Permit *0101*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 19, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 17, 1915* to *June 19, 1915* that I saw her alive on *June 19, 1915* and that death occurred, on the date stated above, at *1:45* p.m.

The CAUSE OF DEATH* was as follows:

Infection of spheroidal cells Septic meningitis
(Duration) *2* yrs. *2* mos. *—* ds.CONTRIBUTORY
(Secondary)(Signed) *J. S. Shields* M.D.
June 19, 1915 (Address) *Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *2* yrs. *2* mos. *—* ds. In the State *2* yrs. *2* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1219 Roanoke St. Roanoke*

19-PLACE OF BURIAL OR REMOVAL.

Roanoke, Va.

DATE OF BURIAL.

June 19, 1915

20-UNDERTAKER

Henry W. Meas ADDRESS *1205 N. Calver St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86145

C86145

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

I HEREBY CERTIFY That I attended deceased from

May 15 1915 to June 18 1915

that I saw her expire on June 18 1915

and that death occurred, on the date stated above, at 12²² m.

The CAUSE OF DEATH* was as follows:

Generalized Tuberculosis -
Pulmonary Tuberculosis - Tuberculosis
of Lungs -
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed)

June 18, 1915 (Address) John Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Charles Lane New York June 19, 1915

20-UNDERTAKER

ADDRESS

H. Sander Sons 1710 Reed St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86146

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86146

CERTIFICATE OF DEATH

1 PLACE OF DEATH

Colored Aged Women's & Men's Home

CITY OF BALTIMORE: (No. *14*)

ST. *14*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Prucella Murphy

(Residence in Baltimore: No. *1622 David Hill Ave.*)

1622 David Hill Ave.

— yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

Unknown, 1857

7-AGE

58

If LESS than

1 day, hrs.

1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic

9-BIRTHPLACE

(State or country)

Baltimore Co. Md.

10-NAME OF FATHER

Isaac Squirells

11-BIRTHPLACE OF FATHER

(State or country)

Baltimore Co. Md.

12-MAIDEN NAME OF MOTHER

Charlotte

13-BIRTHPLACE OF MOTHER

(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emma Prucella

(Address)

1622 David Hill Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 18, 1915

I HEREBY CERTIFY, That I attended deceased from *June 10, 1915*, to *June 19, 1915*, that I saw her alive on *June 18, 1915*, and that death occurred, on the date stated above, at *4:10* m. The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

Contributory (SECONDARY)

Coronary Sclerosis

(Signed)

Wm. N. S. [Signature]

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *1* yrs. *2* mos. — ds. In the *51* yrs. *5* mos. *5* ds.

Where was disease contracted, if not at place of death?

Colored Aged Women's & Men's Home

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Int. Auburn

June 20, 1915

20-UNDERTAKER

ADDRESS

John H. Treadwell

142 W. Hill St.

JUN 20 1915

HARRY O. ANDERSON

Serial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *400 S Calhoun* ST. *19* WARD)2-FULL NAME *Marie Clarice Souder*(Residence in Baltimore: No. *400 S Calhoun* St. *1* yrs. *10* mos. *25* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

7 / *23* / *1913*
(Month) (Day) (Year)

7-AGE,

1 yrs. *10* mos. *25* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employee):9-BIRTHPLACE,
(State or Country),*Balto., Md*

10-NAME OF FATHER,

*Chas. Fred. Souder*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore Co.*

12-MAIDEN NAME OF MOTHER

*Maggie M. Wagner*13-BIRTHPLACE OF MOTHER
(State or Country),*Balto. Co. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mother*(Address) *400 S Calhoun*

15-

*JUN 20 1915**HARRY O. ANDREWS,**191. Permitted Permit Clerk,*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 18, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 14*, 1915, to *June 18*, 1915, that I saw her alive on *June 18*, 1915, and that death occurred, on the date stated above, at *2* p.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia
(Duration) *7* ds.CONTRIBUTORY
(Secondary)(Signed) *Edward A. Morgan*, M.D.
6/18, 1915. (Address) *1500 W. 1st*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *10* mos. *25* ds. In the State *1* yrs. *10* mos. *25* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St Peter Cemetery**June 20, 1915*

20-UNDERTAKER

ADDRESS

John J. Fields 1200 N. Lombard

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86148

C86148

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6. DATE OF BIRTH

June

18, 1915

(Month)

(Day)

(Year)

7. AGE

20

yrs.

mos.

ds.

If LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE (State or country)

Baltimore

PARENTS

10. NAME OF FATHER

Mr. Lewis

11. BIRTHPLACE OF FATHER (State or country)

Virginia

12. MAIDEN NAME OF MOTHER

May Nelson

13. BIRTHPLACE OF MOTHER (State or country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edwin Lake

(Address)

1371 N. Stricker

15.

JUN 20 1915

HARRY O. ALLEN, Jr.
Bureau of Health

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6/19

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

6/16

1915, to, 6/19

1915

that I saw him alive on 6/15, 1915

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Dr. Foster - enteritis

Contributory (SECONDARY)

(Duration) yrs. mos. ds. 4 ds

(Signed)

W. B. Smith

M. D.

6/19, 1915 (Address) 239 D. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Ambrose

June 20, 1915

20. UNDERTAKER

ADDRESS

Sam'l W. Hensley 578 N. Biddle

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 598 W. Preston street, St. 17 WARD)

2-FULL NAME Richard Cockey,

(Residence in Baltimore: No. 598 W. Preston street,

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, Married, (Write the word.)

6-DATE OF BIRTH, Unknown, / (Month) (Day) (Year)

7-AGE, 52 ? yrs. ? mos. ? ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Coal dealer, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Jacob Cockey,

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Unknown,

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosie Butler, daughter,

(Address) 598 W. Preston street.

15- JUN 20 1915. HARRY O. ANDREWS,

Filed Serial Permit Officer Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Trauma of Kidney and other Viscera caused by the kicking of a horse...

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Frederick Kumpel M. D. (Coroner.)

June 17, 1915 (Address) 3310 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 6/20 1915

20-UNDERTAKER, ADDRESS, Samuel J. Hensley 578 N. Biddle

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widower

6-DATE OF BIRTH

April

14, 1833

7-AGE

82

2

6

ds.

or — min.?

If LESS than

1 day, — hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work

Retired Coal

(b) General nature of industry, business, or establishment in which employed (or employer)

Miner

9-BIRTHPLACE

(State or country)

Ireland

10-NAME OF FATHER

Patrick Doran

11-BIRTHPLACE OF FATHER
(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Martha Loftus

13-BIRTHPLACE OF MOTHER
(State or country)

Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wiles Doran

(Address)

1550 Forendsbury Pl.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 20, 1915

17- I HEREBY CERTIFY, That I attended deceased from

April 17, 1915, to June 20, 1915.

that I saw him alive on June 20, 1915.

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

Contributory
(SECONDARY)

(Duration) — yrs. — mos. — ds.

Old age

(Signed) Asa L. Wessels M. D.

June 20, 1915. (Address) 2565 Fred. ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Taylor Co. Pa.

June 21, 1915

20-UNDERTAKER

ADDRESS

Joseph B. Cook

1003 N. Balto

JUN 20 1915

HARRY O. ARKLENS,

Serial Permit Clerk

REGISTRAR

C86151

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86151

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Summit Hospital 16* ST. WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and set out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *1029 Brandy Ave.*St. *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH,

*Jan 13th**1850*

7-AGE,

*65**5* yrs. *7* mos. ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Cigar Maker*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

W.D. (Balto City)

10-NAME OF FATHER,

Valentine Dearing

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Dora Gorman

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Dearing*(Address) *1029 Brandy Ave*

15-

JUN 20 1915

HARRY O. ANDREWS,

Filed....., 191

Serial Permit Olor

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*June 20, 1915*17- I HEREBY CERTIFY, That I attended deceased from *Apr 27* 1915, to *June 20* 1915, that I saw him alive on *June 20* 1915, and that death occurred, on the date stated above, at *9.40 a.m.* The CAUSE OF DEATH* was as follows:*Parasurina of Bloodies*

CONTRIBUTORY (Secondary)

Cholera (Signed) *Cholera* M. D. *June 20, 1915* (Address) *Summit Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs. *1* mos. *28* ds. In the *65* yrs. mos. ds.Where was disease contracted, if not at place of death? *Usual Residence*Former or usual residence *1029 Brandy Ave*

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

June 23, 1915

20-UNDERTAKER

G. J. Walker

ADDRESS

723 Whelan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

CITY OF BALTIMORE: (No.

REGISTERED NO. C.

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Penna ave

15-

JUN 20 1915

HARRY O. ANDREWS,

HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 19, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 18, 1915, to June 19, 1915, that I saw him alive on June 19, 1915, and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH* was as follows:

Ac. pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY Ac. pneumonia

(Duration) yrs. mos. ds.

(Signed) J. C. Easton M. D.

June 19, 1915 (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death? 569 Union St.

Former or usual residence 569 Union St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Samuel Brown

June 21, 1915

20-UNDERTAKER

ADDRESS 916

Daniel Easton

Penna ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86153

C86153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *500 1/2 Biddle* ST.; *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *500 1/2 Biddle* ST.; *—* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Dark*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

May 19, *1914*
(Month) (Day) (Year)

7-AGE,

11 yrs., *—* mos., *—* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....*none*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

Richard Haynes
(State or Country), *MD*

12-MAIDEN NAME OF MOTHER,

E Haynes
(State or Country), *VA*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Richard Haynes*(Address) *500 1/2 Biddle St.*

15-

JUN 20 1915

HARRY O. ANDREWS,

Filed *1915* *June 20* *1915* *10:12* *AM* *City of Baltimore*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

6, *19*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 10* *1915* to *June 19* *1915*, that I saw her alive on *June 18* *1915* and that death occurred, on the date stated above, at *4 a* m. The CAUSE OF DEATH was as follows:*Local Pneumonia*
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)*Toxemia*
(Signed) *Dr. H. Thompson* M. D.
June 19, *1915* (Address) *1019 N. E. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the.....yrs.....mos.....ds. State.....

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Funeral Home

DATE OF BURIAL,

June 20, *1915*.

20-UNDERTAKER

Harold Easter

ADDRESS

916 Remora

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

86154

71001 x

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of a street and number and fill out No. 18.)

FULL NAME *Nelville Dorrice A. Thibault*

(Residence in Baltimore: No. 107 Waverly Hospital - St.; yrs., mos., 5 ds.)

MEDICAL CERTIFICATE OF DEATH.

3-SEX, *Boy* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, *Single*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH, June 15th 1915, 1.....
(Month) (Day) (Year)

7-AGE, yrs. mos. 5 da. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),
Baltimore Maryland

10-NAME OF FATHER. *James J. Smith*

11-BIRTHPLACE
OF FATHER
(State or Country).

12-MAIDEN NAME
OF MOTHER

13-BIRTHPLACE
OF MOTHER
(State or Country), *West Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *W. W. Garman*

(Address) 171 Main Street, Portland, Me.

15 JUN 20 1915 HARRY G ANDREWS,

Filed....., 1913 Serial Permit Clerk.
Registrar.

16-DATE OF DEATH, June 20, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1915, to June 20 1915, that I saw him alive on June 20 1915, and that death occurred on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:
 Intestinal Obstruction
 due to Volvulus

..... (Duration)..... yrs..... mos..... 25 ds.
 CONTRIBUTORY *For initiation*
 (Secondary).....

..... (Duration)..... yrs..... mon..... ⁵ da.

(Signed) W. L. Jones N. D.

June 20, 1912. (Address) W. S. and H. S. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death			In the State		
Yrs.	Mos.	Ds.	Yrs.	Mos.	Ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

[illegible]

Clarksburg W. Va. 6-20, 1915.

20-UNDERTAKER	ADDRESS
Henry W Jenkins	Mculloh & Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86155

C86155

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Union Protestant Infirmary

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1514 Division

ST.:

14

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Montgomery German

(Residence in Baltimore: No.

Union Protestant Infirmary

yrs. mos. 21 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 18, 1900
(Month) (Day) (Year)

7-AGE,

15 yrs. — mos. 2 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),

North Carolina

10-NAME OF FATHER,

Beverly S. German

11-BIRTHPLACE OF FATHER
(State or Country),

North Carolina

12-MAIDEN NAME OF MOTHER

Isabelle Montgomery

13-BIRTHPLACE OF MOTHER
(State or Country),

North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Beverly S. German

(Address).

Raleigh N.C.

15-

JUN 21 1915 ROBERT KRAUTER, Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 20, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 31 1915, to June 20 1915, that I saw him alive on June 20 1915, and that death occurred, on the date stated above, at 3⁵⁰ P.m.

The CAUSE OF DEATH* was as follows:

Septicemia, staphylococcus

(Post-operative)

(Operation June 2, 1915)

Tuberculosis of Elbow

(Duration) yrs. mos. 17 ds.

CONTRIBUTORY

Pneumonia

(Duration) yrs. mos. 7 ds.

(Signed)

R. F. Kieffer M. D.

June 20, 1915 (Address) 1514 Division St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

21 ds.

State

yrs.

mos.

21 ds.

Where was disease contracted, if not at place of death?

Union Protestant Infirmary

Former or usual residence

Raleigh, N.C.

19-PLACE OF BURIAL OR REMOVAL,

Raleigh N.C.

DATE OF BURIAL,

June 21, 1915

20-UNDERTAKER

Henry W. Jenkins Sons Co Raleigh N.C.

ADDRESS

Raleigh N.C.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86136

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 C86136

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1210 E. North Ave.* ST. *9* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1210 E. North Ave.* St. *9* yrs. *8* mos. *7* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widower*

6-DATE OF BIRTH.

Sep 2, 1841
(Month) (Day) (Year)

7-AGE.

73 yrs. *8* mos. *7* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Gilder*
(b) General nature of industry, business, or establishment in which employed (or employer). *Retired*

9-BIRTHPLACE, (State or Country).

Balt. - Md

10-NAME OF FATHER.

Don't Know

11-BIRTHPLACE OF FATHER (State or Country).

Don't Know

12-MAIDEN NAME OF MOTHER

Don't Know

13-BIRTHPLACE OF MOTHER (State or Country).

Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. H. Lillian Hoenfritz*(Address) *1210 E. North Ave.*

15-

JUN 21 1915

ROBERT . KRAUTER

Curial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 18, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*June 15, 1915 to June 18, 1915*that I saw him alive on *June 18, 1915*and that death occurred, on the date stated above, at *9* o'clock *pm*.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) *3* yrs. *3* mos. *3* ds.

CONTRIBUTORY (Secondary)

Arterio Sclerosis
(Duration) *3* yrs. *3* mos. *3* ds.
(Signed) *Thos. J. Gentry* M. D.
June 19, 1915 (Address) *624 N. Mount St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *73* yrs. *8* mos. *7* ds. In the State *73* yrs. *8* mos. *7* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

London Park

DATE OF BURIAL.

June 21, 1915

20-UNDERTAKER

William Book

ADDRESS

502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86157

HEALTH DEPARTMENT-CITY OF BALTIMORE

C86157

1. PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *2536 Frederick Ave* ST. *20* WARD)

2. FULL NAME *Marie B. Nelestein*

Residence in Baltimore: No. *2536 Frederick Ave* Str. *60* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widow

6. DATE OF BIRTH

May

15, 1834

7. AGE

81

1 yrs. *4* mos. *4* ds.

If LESS than
1 day, hrs.

or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE
(State or country)

Germany

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER
(State or country)

Germany

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER
(State or country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Christian Thon*

(Address) *2436 Frederick Ave*

15.

JUN 21 1915

ROBERT . KRAUTER,

Chief Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

19

1915

17. I HEREBY CERTIFY, That I attended deceased from *April 10*, 191*5*, to *June 19*, 191*5*, that I saw her alive on *June 18*, 191*5*, and that death occurred, on the date stated above, at *2 a.* m. The CAUSE OF DEATH* was as follows:

Bright's Disease

Contributory (SECONDARY)

Old age

(Duration)

4

yr. mos. ds.

(Signed), *asa L. Bessels* M. D.
June 19, 1915 (Address) *2565 Frederick Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the Where was disease contracted, If not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Western Cemetery

DATE OF BURIAL

June 21, 1915

20. UNDERTAKER

John Brown & Son 701 Hollins

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 Rock2-FULL NAME Ernest HartelResidence in Baltimore: No. 300 Rock

REGISTERED NO. C

ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 18 yrs. 8 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

October 23, 1914
(Month) (Day) (Year)

7-AGE,

8 yrs. 8 mos. 8 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore Md.

10-NAME OF FATHER,

Frederick Hartel

11-BIRTHPLACE OF FATHER (State or Country),

Balto. Md.

12-MAIDEN NAME OF MOTHER

Elizabeth England

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Hartel(Address) 300 Rock15-JUN 21 1915

ROBERT KRAUTER

Filed 1915 Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

6 19, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 6-12-1915, to 6-19-1915, that I saw him alive on 6-19-1915, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Phlebotomy(Duration) 12 yrs. 12 mos. 12 ds.

CONTRIBUTORY (Secondary)

Morassum(Duration) 3 yrs. 3 mos. 3 ds.(Signed) O. W. Rausenbach, M. D.6-19-1915 (Address) Univ. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 12 yrs. 12 mos. 12 ds. In the State 12 yrs. 12 mos. 12 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL

June 21, 1915

20-UNDERTAKER

John Brown

ADDRESS

901 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86159

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *579 W Hoffman St.* WARD)

REGISTERED NO. C

2-FULL NAME

Annie Barnes

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *579 W Hoffman St.* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Sept 18, 1891
(Month) (Day) (Year)

7-AGE.

*23**9*

yrs. mos. ds.

If LESS than 1 day.

hrs. or min.

9-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Domestic*10-BIRTHPLACE.
(State or Country),*Baltimore*

10-NAME OF FATHER,

John Cooper

11-BIRTHPLACE OF FATHER

(State or Country),

md

12-MAIDEN NAME OF MOTHER

Annie Plater

13-BIRTHPLACE OF MOTHER

(State or Country),

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Matter Annie Cooper
(Informant)(Address) *579 W. Hoffman St.*

15-

Filed *JUN 21 1915**ROBERT K. KRAUTER*

Surgeon General's Office

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 18, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

*June 2, 1915, to June 18, 1915*that I saw him alive on *June 18, 1915*and that death occurred, on the date stated above, at *8:30 p.m.*

The CAUSE OF DEATH* was as follows:

of tuberculosis and lungs
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)*Lungs* (Duration) yrs. mos. ds.

(Signed)

June 18, 1915 (Address) *708 E. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel

DATE OF BURIAL.

June 21, 1915

20-UNDERTAKER

Robert A. Elliott or Royer

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 C86160

PLACE OF DEATH
CITY OF BALTIMORE: (No. 1722 W. Lombard ST. 19 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Henry Rosendale
(Residence in Baltimore: No. 1722 W. Lombard St. 38 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH Nov 19 1852
(Month) (Day) (Year)

7-AGE 62 yrs. 7 mos. 1 ds. or min.?
If LESS than 1 day, hrs., min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country) Balto

10-NAME OF FATHER Henry Rosendale

11-BIRTHPLACE OF FATHER
(State or country) Germany

12-MAIDEN NAME OF MOTHER Freda Lindner

13-BIRTHPLACE OF MOTHER
(State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry L. Rosendale

(Address) 2042 Hollins St.

15-

JUN 21 1915

ROBERT J. KRAUTH

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 20 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 11 1914, to June 20 1915, that I saw him alive on June 19 1915, and that death occurred, on the date stated above, at 4:15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach

(Duration) 9 yrs. 9 mos. 9 ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) W. H. M. D.
June 20 1915 [Address] 108 N. Patton Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery June 23 1915

20-UNDERTAKER

ADDRESS

Knell & Son 172 W. Pratt

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86161

CERTIFICATE OF DEATH.

120
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No.

208 Ivy alley

(ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

George Jones

(Jones)

(Residence in Baltimore: No.

208 Ivy alley

(St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widowed

6-DATE OF BIRTH,

Unknown, 1836

(Month) (Day) (Year)

7-AGE,

79

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Steridore

9-BIRTHPLACE,

(State or Country),

Virginia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Simon Dixon

(Address)

208 Ivy alley

15-

ROBERT

KRAUTER,

Filed JUN 21 1915

CORIAL

Commit. Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 20, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 4, 1915, to June 20, 1915,

that I saw him alive on June 19, 1915,

and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 8 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

C. J. Welch M.D. (Duration) 2 yrs. 8 mos. ds.

(Signed) M. D.

101 J. (Address) 607 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

U.S. Catholic Cemetery

June 21 1915

20-UNDERTAKER

ADDRESS

Bellevue B. Payne

1028 N. Charles St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Langford 4* ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Archie O'Neil*(Residence in Baltimore: No. *204 W. Saratoga*

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Nov. 25, 1854
(Month) (Day) (Year)

7-AGE,

*60 yrs. 6 mos. 25 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Hotel Keeper

9-BIRTHPLACE,

(State or Country),

Baltimore Md

10-NAME OF FATHER,

Louis O'Neil

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary O'Neil

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lucie O'Neil*(Address) *206 W. Saratoga St.*

15-

JUN 21 1915

ROBERT KRAUTER,

Curial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 16, 1915, to June 19, 1915,
that I saw her alive on *June 19, 1915,*
and that death occurred, on the date stated above, at 10:15 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis
(Duration) yrs. mos. ds.
(Signed) *Edward J. Smith* M. D.
6-20, 1915 (Address) *Mary Langford*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

204 W. Saratoga

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

June 22, 1915

20-UNDERTAKER

Charles E. Branch ADDRESS *802 Madison Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 Division ST. 14 WARD)

2-FULL NAME

Miss Lona Tullman

(Residence in Baltimore: No. 1512 Division St. 14 yrs. 9 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

Sept. 18, 1914
(Month) (Day) (Year)

7-AGE

9 yrs. 1 mos. 1 ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant.

9-BIRTHPLACE
(State or country)

1512 Division St

10-NAME OF FATHER

Robert Tullman

11-BIRTHPLACE OF FATHER
(State or country)

Virginia

12-MAIDEN NAME OF MOTHER

Ida Johnson

13-BIRTHPLACE OF MOTHER
(State or country)

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ida Tullman

(Address)

1512 Division St

15-

JUN 21 1915

ROBERT KRAUTER,
Surgeon Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 19, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 4, 1915, to June 19, 1915, that I saw her alive on June 19, 1915, and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis

Contributory
(SECONDARY)

Pneumonia
(Duration) yrs. mos. ds.

(Signed)

Dr. H. W. Wright
June 20, 1915 (Address) 1209 Reschaw St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Auburn

DATE OF BURIAL

June 21, 1915

20-UNDERTAKER

James H. Dennis

ADDRESS

1323 Reschaw St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86165

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

152 C86165

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *Hebrew Hospital* St. *6* WARD)

2-FULL NAME *Benny Karalaky*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM out (No. 18.)

(Residence in Baltimore: No. *1814 E. Fayette St* St.; yrs. mos. *9* ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

10-DATE OF DEATH *June 20* 1915
(Month) (Day) (Year)

6-DATE OF BIRTH *June 10* 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 11* 1915, to *June 20* 1915, that I saw him alive on *June 19* 1915, and that death occurred, on the date stated above, at *5 a.m.*

7-AGE *9* yrs. mos. ds. If LESS than 1 day, hrs. min.?

The CAUSE OF DEATH* was as follows:

8-OCCUPATION
(a) Trade, profession or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

Hemorrhage, pneumonia

9-BIRTHPLACE (State or country) *Baltimore*

(Duration) yrs. mos. *5* ds.

PARENTS
10-NAME OF FATHER *Morris Karalaky*
11-BIRTHPLACE OF FATHER (State or country) *Russia*
12-MAIDEN NAME OF MOTHER *Pachel Harris*
13-BIRTHPLACE OF MOTHER (State or country) *Russia*

Contributory (SECONDARY)
(Duration) yrs. mos. ds.

(Signed), *M. B. Levin* M. D.
June 20 1915 [Address] *Hebrew Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *9* ds. In the State yrs. mos. *9* ds.

Where was disease contracted, If not at place of death? *Hebrew Hospital*

Former or usual residence *1814 E. Fayette St*

(Informant) *Morris Karalaky*
(Address) *1814 E. Fayette St*

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hebrew Mt Carmel *June 21* 1915

20-UNDERTAKER ADDRESS *1107 E*

S. Linnors Bro *Bulfinch St*

JUN 21 1915 ROBERT KRAUTER,
Filed 1915 Registrar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *413 P. Exeter*)
FULL NAME *Alfred Aquino*
(Residence in Baltimore: No. *413 P. Exeter*)

REGISTERED No. C *104*
ST.: *3* WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)
St.: yrs., — mos. *6* ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)
6-DATE OF BIRTH, *August 15th, 1914*
(Month) (Day) (Year)
7-AGE, — yrs., *10* mos., *5* ds. If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer), *None*
9-BIRTHPLACE, (State or Country), *Baltimore*

PARENTS.
10-NAME OF FATHER, *Dominick Aquino*
11-BIRTHPLACE OF FATHER (State or Country), *Italy*
12-MAIDEN NAME OF MOTHER, *Mary Marino*
13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Dominick Aquino*
(Address) *413 P. Exeter St.*

15-*JUN 21 1915*
Filed..... 191.....

ROBERT KRAUTER, *Permit Clerk*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 20th, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said *inquest*, find that said deceased came to *his* death
(Inquest, au- topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastritis (Dyspepsia)
(Duration) — yrs., *10* mos., *5* ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs., — mos., — ds.
(Signed) *David W. Jones* M. D. (Coroner.)
June 20 1915 (Address) *3116 W. Powell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary
UNDERTAKER
Wendell Lippel & Son

DATE OF BURIAL,

June 21st 1915

ADDRESS

330 S. Bond St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86167

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86167

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,

MARRIED
WIDOWED
OR—DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

PARENTS

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

JUN 21 1915

ROBERT . KRAUTER,
Corial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY That I attended deceased from
June 1, 1915, to June 19, 1915;
that I saw her alive on June 19, 1915,
and that death occurred, on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1615 Harmon* St.; *23* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1615 Harmon* St.; yrs. *6* mos. *23* ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Nov 27, 1914
(Month) (Day) (Year)

7-AGE,

6 yrs. 23 mos. 23 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE,
(State or Country),*Md.*

10-NAME OF FATHER,

*Nick Von-Hagel*11-BIRTHPLACE OF FATHER
(State or Country),*Md.*

12-MAIDEN NAME OF MOTHER

*Anna Bailey*13-BIRTHPLACE OF MOTHER
(State or Country),*England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Von-Hagel
1615 Harmon
(Address)

15-

JUN 21 1915
ROBERT . KRAUTER,
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jun 20, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jun 13, 1915*, to *Jun 20, 1915*, that I saw him alive on *Jun 19, 1915*, and that death occurred, on the date stated above, at *1:15 p.m.*

The CAUSE OF DEATH* was as follows:

*Acute Gastro-Enteritis*CONTRIBUTORY
(Secondary)*Pharyngitis*(Signed) *R. P. Campbell* M. D.
Jun 20, 1915 (Address) *1615 Harmon*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

June 21, 1915

20-UNDERTAKER

R. M. S. Flynn

ADDRESS

1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *841 Leadenhall* ST.; *22* WARD)

2-FULL NAME

(Residence in Baltimore: No. *841 Leadenhall* St.; *55* yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE,

Widower
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May 24, 1831
(Month) (Day) (Year)

7-AGE,

84 yrs. *26* mos. ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Sailor

(b) General nature of industry, business, or establishment in which employed (or employer).

*Retired*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

Wm. Schelhase

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Catherine Lescher

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. Schelhase (Brother)*(Address) *1031 Riverside ave**JUN 21 1915**ROBERT . FRATTER,*

Filed.....

191.

Bar 121 Permit. Clark,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 20, 1915
(Month) (Day) (Year)I HEREBY CERTIFY That I attended deceased from *Feb. 8* 191*5*, to *June 20* 191*5*.that I saw him alive on *June 20* 191*5*,and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

Perna Perforans
(Duration) *10* yrs. mos. ds.CONTRIBUTORY
(Secondary)(Duration) *10* yrs. mos. ds.(Signed) *Henry M. Schelhase**June 20* 191*5* (Address) *933 Harrison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL,

June 23, 1915

20-UNDERTAKER

H. M. Flynn

ADDRESS

1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *St Josephs Hospital* ST.: *8*)

2-FULL NAME

Albert H Buettner

(Residence in Baltimore: No. *2111 Mura*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)

6-DATE OF BIRTH, *Aug 16, 1889* (Month) (Day) (Year)

7-AGE, *25 yrs. 10 mos. 2 ds.* If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Blacksmith* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *Julius Buettner*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Anna Kline*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Julius Buettner* (Address) *Residence Md*

15- *JUN 21 1915* *ROBERT KRAUTER* *Permit Clerk* *Registrar*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 19, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows: *(Suicide) Richardson J. Mearns, Baltimore* (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds. (Signed) *Elyah Russell* (Coroner.) M. D. *June 19, 1915* (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Coronet Cemetery, Reservoir Md* DATE OF BURIAL, *June 22, 1915*

20-UNDERTAKER, *Chas W. Lantz* ADDRESS, *Reservoir Md*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

IF LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

JUN 21 1915

ROBERT J. KRAUTER,

Chief Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an...
(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said...
(Inquest, autopsy or inquiry) and that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia & Cardiac Distention

CONTRIBUTORY
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... da. State... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?...

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86172

CERTIFICATE OF DEATH.

119
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 S. Kenwood ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME William O'Neill(Residence in Baltimore: No. 1023 S. Kenwood ave St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Widowed
(Write the word.)

6-DATE OF BIRTH.

Mar. 28, 1849
(Month) (Day) (Year)

7-AGE.

61 yrs., 2 mos., 22 ds.

10 LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Fireman

(b) General nature of industry, business, or establishment in which employed (or employer).

Universal9-BIRTHPLACE.
(State or Country).New Hampshire

10-NAME OF FATHER.

Not Known11-BIRTHPLACE OF FATHER
(State or Country).Ireland

12-MAIDEN NAME OF MOTHER

Not Known13-BIRTHPLACE OF MOTHER
(State or Country).Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Timothy O'Neill(Address) 1023 S. Kenwood ave.

15-

JUN 21 1915

HARRY O. ANDREWS,

Bartolomew Olen's Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 21, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from June 21, 1915 to June 21, 1915, that I saw him alive on June 21, 1915, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis(Duration) 10 yrs., 10 mos., 10 ds.CONTRIBUTORY
(Secondary)Acute Nephritis(Duration) 2 yrs., 2 mos., 2 ds.(Signed) H. B. Tilton M. D.June 21, 1915 (Address) 3035 O'Donnell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Bro Cathedral

DATE OF BURIAL.

June 23, 1915

20-UNDERTAKER

Stephen J. Fralkowski

ADDRESS

1023 S. Kenwood

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 S Hare St.; 1 WARD)2-FULL NAME Fredericka Wagner(Residence in Baltimore: No. 18 S Hare St St.; — yrs. — mos. — ds.)79
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE, White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow6-DATE OF BIRTH, Apr 2, 1845

(Month) (Day) (Year)

7-AGE, 70 yrs. 2 mos. 18 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Md10-NAME OF FATHER, Nicholas Herder11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Don't know13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Bennett(Address) 18 S Hare St

15-

JUN 21 1915

HARRY O. ANDREWS,

Baltimore City Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20, 1915

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 26, 1915 to June 18, 1915that I saw her alive on June 18, 1915 and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosisCONTRIBUTORY (Secondary) Emphysema(Duration) 1 yrs. 1 mos. — ds.(Signed) John G. O'Connor M.D.June 20, 1915. (Address) 18 S Hare St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western AveDATE OF BURIAL, June 22, 191520-UNDERTAKER W. H. CookADDRESS 1502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No.

St.: — yrs. — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

191

HARRY C. ANDREWS,

Burial Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on June 20, 1915, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 C86175

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2913 E Monument ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Hener(Residence in Baltimore: No. 2913 E Monument

St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH,

June 20, 1915
(Month) (Day) (Year)

7-AGE,

yrs. mos. da.

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Wm Hener

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Mary Branch

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Hener(Address) 2913 E Monument

15-

JUN 21 1915 HARRY O. ANDREWS,

Filed 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 20, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 20, 1915, to June 20, 1915, that I saw her alive on June 20, 1915, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

7 Month Foetus

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) H.B. Tether M. D.June 20, 1915 (Address) 3035 Odumville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Anselm Cemetery, June 21, 1915

20-UNDERTAKER

ADDRESS

George J. Routh 1730 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86176

C86176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

JUN 21 1915

HARRY O. ANDREWS,

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed).....

1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... In the State.....

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1318 h. Mount ST. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James DyerResidence in Baltimore: No. 1318 h. MountSt. 30 yrs., 6 mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male4-COLOR OR RACE. White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married6-DATE OF BIRTH, August 20th, 1863

(Month)

(Day)

(Year)

7-AGE, 51 yrs., 10 mos., — ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). City Street Cleaning Dept9-BIRTHPLACE, (State or Country). County Donegal Ireland10-NAME OF FATHER, Patrick Dyer11-BIRTHPLACE OF FATHER (State or Country). County Donegal Ireland12-MAIDEN NAME OF MOTHER Bridget Dyer13-BIRTHPLACE OF MOTHER (State or Country). County Donegal Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Dyer(Address) 1318 h. Mount St

JUN 21 1915

HARRY O. ANDREWS,

Filed..... 1915
Regist.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20th, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1st 1915, to June 19th 1915, that I saw him alive on June 19th 1915, and that death occurred, on the date stated above, at 8:45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) 1 yrs., 6 mos., — ds.CONTRIBUTORY (Secondary) Asthma(Signed) W. J. Sullivan M. D.
June 21st, 1915. (Address) 1701 h. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral CmnDATE OF BURIAL, June 22nd, 191520-UNDERTAKER Geo. J. RuchADDRESS 1735 Bayford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86178

C86178

62

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2123 Hollins St.: 70 WARD)

2-FULL NAME Alexander C. Berry

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2123 Hollins St.: 50 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-MARRIED Married
(Write the word)

6-DATE OF BIRTH Unknown 1844
(Month) (Day) (Year)

7-AGE 71 yrs. — mos. — ds. or min.?
If LESS than 1 day, hrs., min.?

8-OCCUPATION (a) Trade, profession or particular kind of work. Sheet iron worker
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Richmond Va.

10-NAME OF FATHER Jessie Berry

11-BIRTHPLACE OF FATHER (State or country) Richmond Va.

12-MAIDEN NAME OF MOTHER Sarah Miner

13-BIRTHPLACE OF MOTHER (State or country) Richmond Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Elizabeth Berry

(Address) 2123 Hollins St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1914, to June 19, 1915, that I saw him alive on June 18, 1915, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia
see other side

Contributory (SECONDARY) General Paralysis
(Duration) 2 yrs. — mos. — ds.

(Signed) E. H. Dickey M. D.

June 20, 1915 [Address] 14 N. Monroe St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lyons Park Cemetery JUN 22 1915

20-UNDERTAKER Geo. A. Lerby Baltimore

JUN 21 1915

HARRY O. ANDREWS, REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86179

C86179

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *24 N. Port* ST. *6* WARD)

2-FULL NAME *Joseph Cesie*

(Residence in Baltimore: No. *24 N. Port* St. *1* yrs. *2* mos. ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and NE out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male*

4-COLOR OR RACE *White*

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) *Married*

6-DATE OF BIRTH *March 6th 1852*

(Month)

(Day)

(Year)

7-AGE *63 3 15*

Yrs.

Mos.

Ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9-BIRTHPLACE

(State or country)

Austria

10-NAME OF FATHER

Not Known

11-BIRTHPLACE OF FATHER

(State or country)

Austria

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER

(State or country)

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph V. Cesie
Richmond, Va.

JUN 21 1915

Filed....., 191

HARRY O. ANDREWS,
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 21st 1915*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *June 17th 1915* to *June 21st 1915*

that I saw him alive on *June 20th 1915*

and that death occurred, on the date stated above, at *12³⁰ a.m.*

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

Sudden Heart Failure

(Duration) yrs. mos. ds. *5*

(Signed) *W. A. M. Jr.* M. D.
June 21st 1915 (Address) *1031 N. Caroline St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Redeemer

DATE OF BURIAL

June 23 1915

20-UNDERTAKER

Frank Erach & Son

ADDRESS

1904-6 Westland

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86180

CERTIFICATE OF DEATH.

119
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2531 W. Fayette ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John, J. McQueen

(Residence in Baltimore: No. 2531 W. Fayette St.; Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 4, 1910
(Month) (Day) (Year)

7-AGE,

4 yrs. 11 mos. 14 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

John, J. McQueen

11-BIRTHPLACE OF FATHER
(State or Country),

New York

12-MAIDEN NAME OF MOTHER

May Schreiner

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) May McQueen

(Address) 2531 W. Fayette

JUN 21 1915

HARRY O. ANDERSON

Filed..... 1915 Burial Permit 015, 8. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 20, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15, 1915, to June 20, 1915,

that I saw him alive on June 20, 1915,

and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Anderson M. D.

June 20, 1915 (Address) 2000 North Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Linden Park Cemetery June 22, 1915

20-UNDERTAKER

ADDRESS

Jas. J. Anderson 217 S. Duval

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86181

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* ST. *70* WARD)

2-FULL NAME

(Residence in Baltimore: No. *723 Ramsey* St.; *1* yrs., *6* mos., *16* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

Dec 4, 1915
(Month) (Day) (Year)

7-AGE.

1 yrs., *6* mos., *16* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Infant*9-BIRTHPLACE,
(State or Country).*Maryland Baltimore*

10-NAME OF FATHER.

*William H White Jr*11-BIRTHPLACE OF FATHER
(State or Country).*Maryland*

12-MAIDEN NAME OF MOTHER.

*Gertrude V. Muncher*13-BIRTHPLACE OF MOTHER
(State or Country).*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Gertrude V. Muncher

(Address).

723 Ramsey St.

15-

JUN 21 1915

HARRY O. ANDREWS,

Filed..... 1915 Serial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 20, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *May 3* 1915, to *June 20* 1915, that I saw her alive on *June 19* 1915, and that death occurred, on the date stated above, at *4* a.m.

The CAUSE OF DEATH* was as follows:

Septicemia following cut with broken glass & chloroform by multiple abscesses.
(Duration)..... yrs. *2 1/2* mos. ds.CONTRIBUTORY *Broncho Pneumonia*
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *William B. Blanchard* M. D.*June 20, 1915.* (Address) *Ind. Gen. Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. *1* mos. *17* ds. In the State..... yrs. *17* mos. ds.Where was disease contracted, if not at place of death? *723 Ramsey St.*Former or usual residence *723 Ramsey St.*

19-PLACE OF BURIAL OR REMOVAL.

Louisa Park

DATE OF BURIAL.

20-UNDERTAKER

Penworth & Son
(over)*June 22, 1915.*

ADDRESS

Christman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1837 E Biddle* ST.; *8* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1837 E Biddle* St.; *Life* yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

May 24, 18*45*
(Month) (Day) (Year)

7-AGE,

70 yrs. — *27* mos. — *27* ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Paper Hanger Retired*9-BIRTHPLACE,
(State or Country),*Balto City*

10-NAME OF FATHER,

*Chas A Mettee*11-BIRTHPLACE OF FATHER
(State or Country),*Balto City*

12-MAIDEN NAME OF MOTHER

*Mary Trisby*13-BIRTHPLACE OF MOTHER
(State or Country),*Balto City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas A Mettee

(Address)

1837 E Biddle St

15-

JUN 21 1915

HARRY O. ANDREWS,

191. Serial Permit. Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 20, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 14* 1915, to *June 20* 1915, that I saw him alive on *June 20* 1915, and that death occurred, on the date stated above, at *5:45* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Pneumonia(Duration) yrs. mos. ds. *4* ds.CONTRIBUTORY
(Secondary)*Purulent Bronchitis*(Duration) yrs. mos. ds. *6* ds.(Signed) *Thos E Sherris* M. D.*June 21*, 1915. (Address) *1301 N. B. St. Balto*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*London Park**June 23*, 1915.

20-UNDERTAKER

ADDRESS

*Geo M. Fink**811 N. Wolfe*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CS6183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 169

CS6183

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *Fort Covington* St.: *24* WARD)
2-FULL NAME *Vincent Marsden*
(Residence in Baltimore: No. *Glasgow Rutland* St.: yrs., mos., da.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)
6-DATE OF BIRTH, *Unknown*, 1
(Month) (Day) (Year)
7-AGE, *21* yrs., mos., da.
If LESS than 1 day, ... hrs. or ... mts.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Consulting Engineer*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Lancashire Eng*
PARENTS.
10-NAME OF FATHER, *Unknown*
11-BIRTHPLACE OF FATHER (State or Country), *Unknown*
12-MAIDEN NAME OF MOTHER, *Unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *James H. Leary*
(Address) *69 Buchanan St. Eng*

15- *HARRY O. ANNEW,*
Filed *JUN 21 1915* Burial Permit *Olerk*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 20, 1915*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said *inquiry*
(Inquest, autopsy or inquiry.)
and that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH* was as follows:

Accidental Drowning
(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) ...
(Duration) ... yrs. ... mos. ... da.
(Signed) *John H. Leary* M. D.
(Coroner.)
June 21, 1915 (Address) *517 Litch St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death ... yrs. ... mos. ... da. State ... yrs. ... mos. ... da.
Where was disease contracted, if not at place of death? *X*

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, *Cedar Hill, Md* DATE OF BURIAL, *June 22 1915*
20-UNDERTAKER, *Joseph B. Cook* ADDRESS, *1003 N. Baltimore St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

165 C86181
REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 N Broadway ST. 7 WARD)

2-FULL NAME Samuel J Windsor

(Residence in Baltimore: No. 913 N Broadway St.; — yrs. — mos. — dr.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and IN out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE Married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH Sept 13, 1863
(Month) (Day) (Year)

7-AGE 57 yrs. 9 mos. 6 ds. or min. ? If LESS than 1 day, hrs., min. ?

8-OCCUPATION
(a) Trade, profession or particular kind of work Physicians
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Maryland

10-NAME OF FATHER Saml. J. Windsor

11-BIRTHPLACE OF FATHER (State or country) Maryland

12-MAIDEN NAME OF MOTHER Adeline E. Erms

13-BIRTHPLACE OF MOTHER (State or country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carrie J. Windsor

(Address) 913 N Broadway

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 20, 1915, to June 21, 1915, that I saw him alive on June 21, 1915, and that death occurred, on the date stated above, at 9.9 m.

The CAUSE OF DEATH* was as follows:
Heart Failure
Opium Poisoning.
(Accident of weather side)

Contributory (SECONDARY) Not known

(Signed) Wm. L. H. H. H. M. D.
[Address] 814 N. E. St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death — yrs. — mos. — ds. State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Deal Island Md DATE OF BURIAL June 22, 1915

20-UNDERTAKER Geo M. Frick ADDRESS 811 N. E. St.

15-JUN 21 1915

HARRY O. ANDERSON,
Berial Permit Clerk
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 11 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, Widowed, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

ROBERT . KRÄUTER,
Chief Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on, and that death occurred, on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) E. M. Duncan, M. D.
(Address) Greenmount, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 3 ds. In the State 0 yrs. 0 mos. 3 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 508 Rossiter Ave

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *Spring Garden Trlty of Harbors* ST. *17* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
FULL NAME *Willard Fox*
(Residence in Baltimore: No. *735 W Franklin* St.: yrs. *12* mos. *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
4-COLOR OR RACE, *Colored*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH, *Unknown*, *1* (Month) (Day) (Year)
7-AGE, *33* yrs. *33* mos. *33* ds. If LESS than 1 day, ...hrs. or...min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Librarian*
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), *Va*
PARENTS.
10-NAME OF FATHER, *Unknown*
11-BIRTHPLACE OF FATHER (State or Country), *Va*
12-MAIDEN NAME OF MOTHER, *Betha Dorsey*
13-BIRTHPLACE OF MOTHER (State or Country), *Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *L. Lewis*
(Address) *579 N. Mount*

15- *JUN 22 1915* *ROBERT KRAUTER,*
Filed *191* *Surial Portrait Clerk*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 19, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Edwin Greenleaf* M. D. (Coroner.)

21, 191*5*. (Address) *377 N. Mount*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL:

St. Albans Cemetery June 18/15

20-UNDERTAKER ADDRESS

Walter Owens 235 Pine St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1028 Greenmount Ave* ST.; *10* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *1028 Greenmount Ave* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

..... *June* *21* *1915*
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day.

..... yrs. mos. da. hrs. or. min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

America Balto Md.

10-NAME OF FATHER,

Win J. C. I.

11-BIRTHPLACE OF FATHER

(State or Country),

America

12-MAIDEN NAME OF MOTHER

Anna Knealy

13-BIRTHPLACE OF MOTHER

(State or Country),

America

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Mr. Zuck

(Address).....

1028 Greenmount Ave

15-

JUN 22 1915

Filed.....

191

ROBERT

KRAUTH

Corial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

..... *June* *21* *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 21 1915, to *June 21 1915*,

that I saw him alive on " " 1915,

and that death occurred, on the date stated above, at *5* m.

The CAUSE OF DEATH* was as follows:

not known
Pneumonia + renal death

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *James M. Kinton* M. D.*June 21 1915* (Address) *740 C. Chase St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cathedral June 22 1915

UNDERTAKER

ADDRESS

H. C. Widdifield 914 Greenmount

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2538 Greenmount Ave.* ST. *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Marie White Price(Residence in Baltimore: No. *2538 Greenmount Ave*

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Single*

6-DATE OF BIRTH,

June 3rd, 1866
(Month) (Day) (Year)

7-AGE,

49 yrs. 0 mos. 18 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer) *Housewife*

9-BIRTHPLACE,

(State or Country), *Ind.*

10-NAME OF FATHER,

Joseph H. Youngel.
Ind.

12-MAIDEN NAME OF MOTHER

Marie White

13-BIRTHPLACE OF MOTHER

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph H. Price*(Address) *2538 Greenmount Ave*

15-

JUN 22 1915

Filed

ROBERT J. KRAUTH

Baltimore Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 21st, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*January 10th, 1915, to June 21st, 1915.*that I saw her alive on *June 21st, 1915.*and that death occurred, on the date stated above, at *3.10 PM*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.(Duration) yrs. mos. ds. *4*

CONTRIBUTORY

(Secondary) *Atherosclerosis*(Duration) yrs. mos. ds. *5*(Signed) *Geo. H. Murgatroyd, M.D.**June 21st, 1915.* (Address) *2538 Greenmount Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenmount June 24th, 1915.

20-UNDERTAKER,

ADDRESS

H. C. Muddifield, 917 Greenmount Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 N. Glover ST.; 6 WARD)

REGISTERED NO. C.

2-FULL NAME

Frank M. Wilhelm

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 24 N. Glover St.; 49 yrs., 3 mo., 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Feb 25th, 1866
(Month) (Day) (Year)

7-AGE,

49 yrs., 3 mo., 20 ds.If LESS than 1 day,
... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... Hearse Driver
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),Balto. Md.

10-NAME OF FATHER,

Conrad Wilhelm11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Eatharine Schuessle13-BIRTHPLACE OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eatharine Schuessle(Address) 24 N. Glover St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June, 20 -, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 4-1915 to June 20-1915, that I saw him alive on June 18-1915, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH was as follows:

Pulmonary Tuberculosis.CONTRIBUTORY
(Secondary)(Signed) J. D. Meyer, M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mo. ... ds. In the State... yrs. ... mo. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer Cem. June 23rd, 1915.

20-UNDERTAKER

ADDRESS

Lilly - Zeiler 400 S. W. 4th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15- JUN 22 1915

ROBERT . KRAUTER

Filed....., 191

Burial Permit Clerk

Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

x 76

C86190

1-PLACE OF DEATH *Hebrew Hospital*

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *Ent Monument St.* ST. *7* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

2-FULL NAME *Paul Vogt*

Residence in Baltimore: No. *504 Twelfth St. Balto Co. Md.* St. *17* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Sept. 15, 1897*
(Month) (Day) (Year)

7-AGE *17* yrs. *9* mos. *5* ds. or min. ? If LESS than 1 day, hrs.

8-OCCUPATION *Jim Heenanator*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE *Baltimore Co. Md*
(State or country)

PARENTS
10-NAME OF FATHER *Leonard Vogt*
11-BIRTHPLACE OF FATHER *Germany*
(State or country)
12-MAIDEN NAME OF MOTHER *Margaret Boh*
13-BIRTHPLACE OF MOTHER *Germany*
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Leonard Vogt*
(Address) *504 S. 12th St*

15-
JUN 22 1915 *ROBERT KRAUTER*
Curial Board Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 20, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 17, 1915*, to *June 20, 1915*, that I saw him alive on *June 20, 1915*, and that death occurred, on the date stated above, at *12* P.M.

The CAUSE OF DEATH* was as follows:

Chronic suppurative Otitis media

(Duration) yrs. mos. *21* ds.
Contributory (SECONDARY) *Abscess of Brain*

(Signed), *M. B. Levin* M. D.
June 20, 1915 [Address] *Hebrew Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. In the *18* yrs. mos. ds. State

Where was disease contracted, *504 - 12th St*
If not at place of death ?

Former or usual residence *504 - 12th St*

19-PLACE OF BURIAL OR REMOVAL

MT Carmel Ave

DATE OF BURIAL

June 22, 1915

20-UNDERTAKER

Lilly & Ziehl

ADDRESS

403 S. Waverly

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *513 S. Luzerne* ST. *1* WARD)

2-FULL NAME

(Residence in Baltimore: No. *513 S. Luzerne* St.; yrs. mos. ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Married*

6-DATE OF BIRTH,

Sept 16th, 1870
(Month) (Day) (Year)

7-AGE,

44 yrs. 9 mos. 5 ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Laborer*9-BIRTHPLACE,
(State or Country),*Md*

10-NAME OF FATHER,

Wm Slater

11-BIRTHPLACE OF FATHER

(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Lena

13-BIRTHPLACE OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Margaret Slater*(Address) *513 S. Luzerne*

15-

*JUN 22 1915**ROBERT KRAUTER*

Filed

Carla A. Permitt Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 21st, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 30 1915*, to *June 21st 1915*, that I saw him alive on *June 20th 1915* and that death occurred, on the date stated above, at *12:30 a* m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis(Duration) yrs. mos. *5 1/2* ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *William H. Johnson M. D.**June 21st, 1915* (Address) *217 G. Road*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Trinity Cemetery June 23 1915

20-UNDERTAKER

ADDRESS *2016 Orleans**Philip Herwig*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

C86192

1. PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

1105 Angelle

ST. 17 WARD)

2. FULL NAME

Goldie Burke

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1105 Angelle

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6. DATE OF BIRTH

Dec 20, 1914

(Month)

(Day)

(Year)

7. AGE

6 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE (State or country)

Balto

10. NAME OF FATHER

Edward Jackson

11. BIRTHPLACE OF FATHER (State or country)

Mo

12. MAIDEN NAME OF MOTHER

Hattie Burke

13. BIRTHPLACE OF MOTHER (State or country)

Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hattie Burke

(Address)

1105 Angelle

15.

JUN 22 1915

ROBERT KRAUTER

Chief Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 21, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 15, 1915, to June 21, 1915.

that I saw him alive on June 21, 1915.

and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhea

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

5 mos. 5 ds.

(Signed)

Charles H. Finney M. D.

June 22, 1915 (Address) 714 S. Sharp St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Charles

6/22/15

20. UNDERTAKER

ADDRESS

Sam L. Bradley

15800 Biddle

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *829 Hollins* ST.; *18* WARD)

REGISTERED NO. C

2. FULL NAME

(Residence in Baltimore: No. *829 Hollins* St.; *10* yrs., — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX.

Female

4. COLOR OR RACE,

*White*5. ~~STATUS~~,
MARRIED, *married*
WIDOWED,
OR DECEASED,
(Write the word.)

6. DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7. AGE,

66 yrs. — mos. — ds.

If LESS than 1 day,

hrs. or min.?

8. OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9. BIRTHPLACE,
(State or Country),*Russia*

PARENTS.

10. NAME OF FATHER,

*Kiril Mitritsky*11. BIRTHPLACE OF FATHER
(State or Country),*Russia*

12. MAIDEN NAME OF MOTHER

*Unknown*13. BIRTHPLACE OF MOTHER
(State or Country),*Russia*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louis E. Kahanovitz*(Address) *829 Hollins St.*

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH,

June 21, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 15, 1915, to June 21, 1915,
that I saw her alive on *June 21, 1915,*
and that death occurred, on the date stated above, at *9:30 P. M.*

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy(Duration) yrs. mos. *4* ds.CONTRIBUTORY
(Secondary)*Pulmonary Tuberculosis*
(Duration) yrs. mos. *3* ds.(Signed) *Eugene J. Leopold, M.D.**June 22, 1915* (Address) *803 Park Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Washington Ref. Ch. June 22, 1915

20. UNDERTAKER

ADDRESS

S. Kinsman & Co. Balto. Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 22 1915

ROBERT . KRAUTER

Filed..... 191... *Medical Permit Clerk*
Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital*)ST.: *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

3-FULL NAME

Cyrus A. Byers(Residence in Baltimore: No. *Emerson Hotel*)St.: *5* yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May 30, 1853
(Month) (Day) (Year)

7-AGE,

62 yrs. — *22* mos. — ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*Pres. of Sand Co.*9-BIRTHPLACE,
(State or Country),*U.S.A. Tennessee*

10-NAME OF FATHER,

*Charles P. Byers*11-BIRTHPLACE OF FATHER
(State or Country),*Springfield Mass*

12-MAIDEN NAME OF MOTHER

*Emaline Cook*13-BIRTHPLACE OF MOTHER
(State or Country),*East Tenn.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Ida V. White*(Address) *202 S. 39th Phila Pa*

15-

JUN 22 1915**ROBERT . KRAUTER,**

Filed..... 191

Bureau of Health

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 22, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 20 1915*, to *June 22 1915*, that I saw him alive on *June 22, 1915*, and that death occurred, on the date stated above, at *8:30 a.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)*Typhoid fever, pneumonia, (old lower)*

(Duration).....yrs.....mos.....ds.

(Signed) *Michael A. H. Brown* M. D.*June 22, 1915.* (Address) *1634 E. 12th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. — mos. *3* ds. In the ? yrs. — mos. — ds. State ?Where was disease contracted, if not at place of death? *Emerson Phila. Pa*Former or usual residence *Emerson Hotel*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Philadelphia Pa June 22, 1915.

20-UNDERTAKER

ADDRESS

*Joe Cook**1003 Walnut St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2200 Oak St.* St.; *63* yrs. *7* mos. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widowed

6-DATE OF BIRTH

known
(Month) (Day) (Year)

7-AGE

63 yrs. *7* mos. *7* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*at home*

9-BIRTHPLACE, (State or Country).

Maryland

10-NAME OF FATHER

John Hauer

11-BIRTHPLACE OF FATHER (State or Country).

Ind

12-MAIDEN NAME OF MOTHER

Elizabeth Young

13-BIRTHPLACE OF MOTHER (State or Country).

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. B. F. Bergeron*(Address) *2200 Oak St.*15- *JUN 22 1915*

ROBERT . HENRY

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 21, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 21 1915*, to *June 21 1915*, that I saw her alive on *June 21 1915*, and that death occurred, on the date stated above, at *9:45 P.* m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation(Duration) *7* yrs. *7* mos. *1* ds.

CONTRIBUTORY (Secondary)

(Duration) *7* yrs. *7* mos. *7* ds.(Signed) *David Streett* M. D.*June 22, 1915* (Address) *712 Park Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs. *0* mos. *1* ds. In the *63* yrs. *7* mos. *7* ds. State

Where was disease contracted, if not at place of death?

Former or usual residence *2200 Oak Street*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Frederick Md**June 24, 1915*

20-UNDERTAKER

ADDRESS

*William Cook**502 E. Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86196

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *1814 E Lanvale*)

2-FULL NAME

Emma Pryor

(Residence in Baltimore: No. *1814 E Lanvale*)

St.: *16* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED
WIDOWED
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Feb 17, 1868
(Month) (Day) (Year)

7-AGE,

47 yrs. 4 mos. 7 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Sales Lad.

9-BIRTHPLACE, (State or Country),

Md

10-NAME OF FATHER,

William Stinson

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Susan Corington

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

William Stinson
1814 E Lanvale St.

15-

JUN 22 1915

Filed

ROBERT J. KELLY

CITY OF BALTIMORE

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, au-

Inquest and that said deceased came to *her* death today or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Olyak Russell* M. D.

June 21, 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. James Church, Md. *June 24, 1915*

UNDERTAKER

ADDRESS

W. J. Turner *1442 N. Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE—C86197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1730 Orleans ST.) 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1730 Orleans St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

Black.5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED. single
(Write the word)

6-DATE OF BIRTH,

July 5, 1901
(Month) (Day) (Year)

7-AGE,

13 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

School-boy9-BIRTHPLACE,
(State or Country),md.

PARENTS.

10-NAME OF FATHER,

William Cooper11-BIRTHPLACE OF FATHER
(State or Country),md.

12-MAIDEN NAME OF MOTHER

Laura Johnson13-BIRTHPLACE OF MOTHER
(State or Country),md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Cooper(Address) 1730 Orleans

15-

JUN 22 1915

191

ROBERT K. BRADY

Surgeon General

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 18, 1915, to June 19, 1915that I saw him alive on June 19, 1915and that death occurred, on the date stated above, at 6:40 m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal Catarrh

(Duration) yrs. mos. ds.

CONTRIBUTORY Cardiac aneurysm
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. C. Robinson M. D.June 21, 1915 (Address) 611 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laura CJune 23 1915

UNDERTAKER

ADDRESS

Robt. A. Elliott506 East

N. B. Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86198

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86198

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *Mercy Hospital* ST. *13* WARD)

2-FULL NAME

(Residence in Baltimore: No. *2309 Madison Ave* St.; — yrs., — mos. — ds.)79
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)
6-DATE OF BIRTH. *Mar 16*, 18*50*
(Month) (Day) (Year)

7-AGE. *65* yrs. *3* mos. *6* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Salesman*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *MD.*

10-NAME OF FATHER *Samuel Hecht*

11-BIRTHPLACE OF FATHER (State or Country), *MD.*

12-MAIDEN NAME OF MOTHER *Hennetta Stern*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Record Merg. Dept.*(Address) *Calvert St.*

15-JUN 22 1915. HARRY O. ANDREWS,
Filed. 191. *Barial Permit* Clerk's
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 22*, 19*15*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 17*, 191*5*, to *June 22*, 191*5*, that I saw him alive on *June 22*, 191*5*, and that death occurred, on the date stated above, at *12:00* p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis
(Duration) *7* yrs. *4* mos. *4* ds.

CONTRIBUTORY (Secondary) *Ac. Cardiac Dilatation*

(Duration) *4* yrs. *7* mos. *2* ds.

(Signed) *Edward J. Smith* M. D.

June 22, 191*5* (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. *5* ds. In the *State* *MD.* yrs. mos. ds.

Where was disease contracted, if not at place of death? *2309 Madison Ave*

Former or usual residence *2309 Madison Ave*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Maryland Cemetery *June 24*, 191*5*

20-UNDERTAKER ADDRESS

Andrews & Co *1611 Madison Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Josephs Hospital*)

ST. *3*

WARD)

REGISTERED No. C

2-FULL NAME

Charles Pitchford

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. *812 E Pratt*

St. yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

unknown

(Month)

(Day)

(Year)

7-AGE,

25

Yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

North Carolina

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER

(State or Country),

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Information derived from

(Address)

Police Dept

15 JUN 22 1915

Filed....., 191..

HARRY O. ANDREWS,

Marial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

12, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH was as follows:

Stab wound of heart and internal hemorrhage, the result of Homicide

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

Wm. M. S. Searcy

(Coroner.)

June 16, 1915. (Address) *1729 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY

JUN 22 1915

20-UNDERTAKER *Health*

ADDRESS

DR. WM. E. WOODALL

C86200

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86200

CERTIFICATE OF DEATH.

PLACE OF DEATH

Pronounced dead Mary Hospital
CITY OF BALTIMORE (No.)

ST. 17 WARD

REGISTERED No. C

FULL NAME

Carl H. Hoffstetter

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2456 York Road.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male. 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Printer (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Records.

(Address)

15- JUN 22 1915 HARRY O. ANDREWS,

Filed 101. HARRY O. ANDREWS,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Suicide - Gun Wounded. Jumped into harbor off Pier #2 Pratt St. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. R. Chambers M. D. (Coroner.)

June 17, 1915 (Address) 18 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

PUBLIC CEMETERY JUN 22 1915

20-UNDERTAKER ADDRESS

Commissioner Health.

Per. Wm. E. WOODSALL.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x164

C86201

PLACE OF DEATH

CITY OF BALTIMORE (No. *Caton near Wilkens Ave 20* WARD)

2-FULL NAME

John Farmer(Residence in Baltimore: No. *(Chesapeake House) Sparrow Point*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

about 45

yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Day Labour*

9-BIRTHPLACE, (State or Country),

Unknown

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 22 1915

HARRY O. ANDREWS

Burial Permit 019

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 10th, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry)thereon and from the evidence obtained by said *inquiry* (Inquest, au-*inquiry* and that said deceased came to *his* death topsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental drowning
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Sam'l M. D.* M. D.*June 17th, 1915* (Address) *2302 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*PUBLIC CEMETERY*DATE OF BURIAL
JUN 22 1915

20-UNDERTAKER

Commissioner Health

ADDRESS

Per. Wm. E. WOODALL.

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

086202

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

169

086202

PLACE OF DEATH
Found off Pier # 6 Pratt St. 4
CITY OF BALTIMORE (NO. ST. WARD)

REGISTERED NO. C

2-FULL NAME

A. Peterson

(Residence in Baltimore: No.

Unknown

St.; yrs., mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male. 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) 2
6-DATE OF BIRTH. 2, 1 (Month) (Day) (Year)

7-AGE. about 45 yrs. mon. ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Sailor (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), 1

10-NAME OF FATHER, 1

11-BIRTHPLACE OF FATHER (State or Country), 1

12-MAIDEN NAME OF MOTHER, 1

13-BIRTHPLACE OF MOTHER (State or Country), 1

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Records.

(Address).....

15- JUN 22 1915 HARRY O. ANDREWS Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Found June 5, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, an

Inquest find that said deceased came to his death today (inquest or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned How caused unknown

No signs of injury. (Duration) yrs. mon. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mon. ds.

(Signed) J. H. P. M. D. (Coroner.)

June 12, 1915. (Address) 18 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY, DATE OF BURIAL, JUN 22 1915

20-UNDERTAKER, Commissioner Health, ADDRESS

REV. W. E. WOODALL.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(86203)

HEALTH DEPARTMENT—CITY OF BALTIMORE

(86203)

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Foot of James & Wolfe* St. *W* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Unknown* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE, *Not known*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Not known, *1*
(Month) (Day) (Year)

7-AGE,

30 yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Not known*

(b) General nature of industry, business, or establishment in which employed (or employer). *Not known*

9-BIRTHPLACE,

(State or Country), *Not known*

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER

(State or Country), *Not known*

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed *JUN 22 1915* *HARRY O. ANDREWS,*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 18th, *1915*.
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to *his* death (Inquest, au-
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. J. Jones* M. D.

(Coroner.)

June 20, 1915 (Address) *316 S. 16th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,
PUBLIC CEMETERY

JUN 22 1915

20-UNDERTAKER

Commissioner Health.

ADDRESS

Per. Wm. E. WOODALL

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86204

92 C86204

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

F. A. Hermann Gen. Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No. 11224 Mount

ST. 16 WARD)

2-FULL NAME

John Lucien (Lucien)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1618 Riggo Ave

St. yrs. 1 mos. 22 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

March 29, 1915
(Month) (Day) (Year)

7-AGE,

yrs. 2 mos. 20 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country)

Bact. Md

10-NAME OF FATHER

Henry Lucien

11-BIRTHPLACE OF FATHER (State or Country)

Ann Arundel Co

12-MAIDEN NAME OF MOTHER

Mary Sadonia Lucien

13-BIRTHPLACE OF MOTHER (State or Country)

Ann Arundel Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-JUN 26 1915.

HARRY O. ANDREWS,

Filed

191

Burial Permit Clerk Registrar.

16-DATE OF DEATH,

June 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 9, 1915 to June 19, 1915,

that I saw him alive on June 19, 1915,

and that death occurred, on the date stated above, at 8:10 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

Acute Bronchitis

(Duration) yrs. 2 mos. 2 ds.

(Signed)

Wm. Daw M. D.

June 19, 1915 (Address) 11224 Mount St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 2 mos. 22 ds. In the State yrs. 2 mos. 20 ds.

Where was disease contracted, if not at place of death?

In home

Former or usual residence

1618 Riggo Ave

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

JOHNS HOPKINS HOSPITAL

JUN 26 1915

20-UNDERTAKER

ADDRESS

Commissioner Health

FOR ANATOMICAL PURPOSES.

N. B.—Every item of information should be carefully supplied. AGE must be stated EXACTLY. PHYSICIAN'S name and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86205

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86205

1. PLACE OF DEATH

CERTIFICATE OF DEATH

40
REGISTERED NO. C

CITY OF BALTIMORE (No. 865 Harlem Ave. ST. 17 WARD)

2. FULL NAME Emily A. Taylor (Taylor)

(Residence in Baltimore: No. 865 Harlem Ave. Sr. 25 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (Write the word)

6. DATE OF BIRTH Unknown, 1 (Month) (Day) (Year)

7. AGE 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9. BIRTHPLACE (State or country) Virginia

PARENTS 10. NAME OF FATHER Robert Murphy 11. BIRTHPLACE OF FATHER (State or country) Virginia 12. MAIDEN NAME OF MOTHER Mary Jefferies 13. BIRTHPLACE OF MOTHER (State or country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. H. Hancock (Address) 865 Harlem Ave.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1915, to June 21, 1915, that I saw her alive on June 21, 1915, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows:

Carcinoma Liver and Gall bladder (Duration) yrs. 3 mos. ds. Contributory (SECONDARY) (Signed) John S. Bishop M. D. June 21, 1915 (Address) 828 N. Conwellton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL June 23, 1915

20. UNDERTAKER Geo. W. Little ADDRESS 531 Fremont Ave.

JUN 22 1915

Filed

191

HARRY O. ANDERSON,

Barial Permit Clerk, REGISTRAR

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81

C86206

PLACE OF DEATH *Announced dead Mary Hospital 5*
CITY OF BALTIMORE (No. *5* ST. *5* WARD)
FULL NAME *William Saunders*
(Residence in Baltimore: No. *522 Somerset St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*
(Write the word.)
6-DATE OF BIRTH, *Unknown, 1*
(Month) (Day) (Year)
7-AGE, *46* yrs. mon. ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Waiter*
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), *Norfolk, Va.*
PARENTS.
10-NAME OF FATHER, *Unknown*
11-BIRTHPLACE OF FATHER (State or Country), *Unknown*
12-MAIDEN NAME OF MOTHER *Unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Celestine Saunders (Wife)*
(Address) *522 Somerset St.*

15- JUN 22 1915, JUN 22 1915
Filed..... 191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, *June 20, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry*
(Inquest, funeral or inquiry.)

thereon and from the evidence obtained by said *inquiry*
(Inquest, funeral or inquiry.) and that said deceased came to *this* death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary haemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *ruptured thoracic aneurysm*

(Duration) yrs. mos. ds.

(Signed) *Harold B. Chamberlain* M. D.
(Coroner.)

June 22, 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL,

Laurel Cemetery *June 24 1915*

20-UNDERTAKER ADDRESS

Relix B. Pye *102 E. North St.*

C86207

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86207

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *20* WARD)FULL NAME *Katherine Crout*(Residence in Baltimore: No. *2524 Wilkins Ave.* St.; *—* yrs., *—* mos., *—* ds.)REGISTERED NO. C *130*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

January 6, 1894
(Month) (Day) (Year)

7-AGE,

21 yrs. 5 mos. 15 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE,

(State or Country), *ind.*

PARENTS.

10-NAME OF FATHER,

Wm. Henken

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Julia Ritter

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *O. Phelps*(Address) *Johns Hopkins Hosp.*

15-

*JUN 22 1915**HARRY O. ANDERSON*

Filed..... 191...

*1915**Barial Permit*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 21, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *June 14, 1915* to *June 21, 1915*, that I saw her alive on *June 21, 1915*, and that death occurred, on the date stated above, at *5 45 a.m.*

The CAUSE OF DEATH* was as follows:

*Peritonitis... perforative... following operation on infected... (Pelvic Abscess). (Duration).... yrs.... mos. 4 ds.*CONTRIBUTORY... *Endocarditis* (Secondary)

(Duration).... yrs.... mos. ? ds.

(Signed) *H. M. W. M. D.**June 21, 1915* (Address) *Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs.... mos. 7 ds. In the *21* yrs. *5* mos. *15* ds. State

Where was disease contracted, if not at place of death?

Former or usual residence *2524 Wilkins Ave.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oakland Cemetery June 23, 1915

20-UNDERTAKER

ADDRESS

Scott Farley Talbot & Lombard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. INDICATE MODE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86208

CERTIFICATE OF DEATH.

92 C86208
REGISTERED NO. C

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *244 Bowena Ct* ST. *18* WARD)

2—FULL NAME

(Residence in Baltimore: No. *244 Bowena Ct* St. *11* yrs., *7* mon. *26* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3—SEX, *Male* 4—COLOR OR RACE, *Col* 5—SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Child*6—DATE OF BIRTH, *Oct 26th*, 1903
(Month) (Day) (Year)7—AGE, *11* yrs., *7* mos., *26* ds. If LESS than 1 day, ... hrs. or ... min.?8—OCCUPATION:
(a) Trade, profession, or particular kind of work. *Child*
(b) General nature of industry, business, or establishment in which employed (or employer). *at school*9—BIRTHPLACE, (State or Country), *Baltimore Md*10—NAME OF FATHER, *Amuel Williams*11—BIRTHPLACE OF FATHER (State or Country), *Baltimore Md*12—MAIDEN NAME OF MOTHER *Cassie Brooks*13—BIRTHPLACE OF MOTHER (State or Country), *Baltimore Md*

14—THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Samuel Williams*(Address) *244 Bowena Court*

15—

Filed *JUN 22 1915* HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16—DATE OF DEATH, *June 21st*, 1915
(Month) (Day) (Year)17— I HEREBY CERTIFY, That I attended deceased from *June 10* 1915, to *June 21* 1915, that I saw him alive on *June 20* 1915 and that death occurred, on the date stated above, at *6* m.

The CAUSE OF DEATH* was as follows:

Infant Pneumonia
(Duration) ... yrs. ... mos. *11* ds.

CONTRIBUTORY (Secondary) ...

(Signed) *J. P. Hadlock* M. D.
421, 1915 (Address) *1724 Calverton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18—LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19—PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

At Auburn *June 24, 1915*
20—UNDERTAKER *Willard Brown* ADDRESS *306 N. Howard St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 C86209

PLACE OF DEATH

CITY OF BALTIMORE (No. *117 N. Bond*)

ST. *3* WARD

REGISTERED No. C

2-FULL NAME

Bessie Pergoff

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *117 N. Bond, Ct.*)

St.; yrs. mos. *10* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

June 12th, 1915
(Month) (Day) (Year)

7-AGE,

10 yrs. *10* mos. *10* ds.

If LESS than 1 day,

...hrs. or ...mins.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

Baltimore

10-NAME OF FATHER,

Louis Pergoff

11-BIRTHPLACE OF FATHER

(State or Country).

Russia

12-MAIDEN NAME OF MOTHER

Anna Udovitch

13-BIRTHPLACE OF MOTHER

(State or Country).

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Bessie Pergoff*

(Address) *117 N. Bond St*

15-

Filed

JUN 22 1915

191

HARRY O. ANDREWS,

Marial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 22nd, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cholera's Bacteria

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *David W. Jones, M. D.*

(Coroner.)

June 22, 1915 (Address) *5116 O'Donnell St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN- SIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Debur Mt Carmel

June 20, 1915

20-UNDERTAKER

ADDRESS

S. L. Linton - Bro

1107 E Baltimore

C86210

C86214

95

REGISTERED NO. C

WARD

2. FULL NAME James J. Alderman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. Salmonville St.; yrs. mos. da.)

MEDICAL CERTIFICATE OF DEATH.

3-SEX. male	4-COLOR OR RACE, white	5-SINGLE, MARRIED, <i>widowed</i> WIDOWED, OR DIVORCED, (Write the word.)
----------------	---------------------------	---

16-DATE OF DEATH June 22, 1915
(Month) (Day) (Year)

6-DATE OF BIRTH, Enkman, 1973
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 21 1915, to June 22 1915 that I saw him alive on June 22 1915 and that death occurred, on the date stated above, at 4:45 p.m.

7-AGE, If LESS than 1 day,
 42 yrs. mos. ds. hrs. or min.?

The CAUSE OF DEATH* was as follows:

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Pulmonary gangrene
(Duration) 7 mos.

9-BIRTHPLACE,
(State or Country), *W. Va.*

CONTRIBUTORY.....
(Secondary)

10-NAME OF FATHER. *Paul*

..... (Duration) yrs. mos. da.

11-BIRTHPLACE
OF FATHER
(State or Country).

(Signed)..... Harry G. Evans M. D.

12-MAIDEN NAME
OF MOTHER

... 1016 - (Address) ...

13-BIRTHPLACE
OF MOTHER
(State or Country).

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant)..... AT Curry

At place of death yrs. 10 mos. In the State yrs. 10 mos.

(Address).....

Where was disease contracted,
if not at place of death?.....

15-JUN 22 1915 HARRY O. ANDERSON

Former or usual residence Belmont N. Va

Filed..... 191.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Registrar.

221 N Branch

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86211

CERTIFICATE OF DEATH

80

C86211

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

1430 Hollins

ST. 19 WARD)

FULL NAME

Wm. A. Walker

Residence in Baltimore: No.

1430 Hollins

St. — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

unknown, 1 —

(Month) (Day) (Year)

7 AGE

57

yrs. — mos. — ds. or min. ?

If LESS than

1 day, — hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Machinist

9 BIRTHPLACE

(State or country)

Ind.

10 NAME OF FATHER

Alex. Walker

11 BIRTHPLACE OF FATHER

(State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Jane Thon

13 BIRTHPLACE OF MOTHER

(State or country)

Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. E. Meredith

(Address)

1430 Hollins

15

JUN 22 1915

HARRY O. ANDREWS,
Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 21, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 17, 1915, to, June 21, 1915.

that I saw him alive on June 21, 1915.

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

known for past 2 mos.

(Duration) — yrs. — mos. — ds.

Contributory (SECONDARY)

(Duration) — yrs. — mos. — ds.

(Signed) John J. King M. D.

June 22, 1915 (Address) 1425 Eastern Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

June 23, 1915

20 UNDERTAKER

George J. Smith

ADDRESS

1505 N. ...

C86212

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. 1* ST., 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *812 S. Grove St.* St. *1* yrs. *5* mos. *9* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

Jan 13, 1915
(Month) (Day) (Year)

7-AGE.

5 mos. 9 da.
If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Infant*9-BIRTHPLACE.
(State or Country).*Balto City Maryland*

10-NAME OF FATHER.

*August Brandt*11-BIRTHPLACE OF FATHER
(State or Country).*Md.*

12-MAIDEN NAME OF MOTHER

*Lizzie Smith*13-BIRTHPLACE OF MOTHER
(State or Country).*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Arceur*(Address) *J. H. Hopk*

15-

JUN 22 1915

HARRY O. ANDREWS

191. *Marital Permit 01A*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 22, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *June 22 1915* to *June 22 1915*, that I saw him alive on *June 22 1915*, and that death occurred, on the date stated above, at *120P* m.

The CAUSE OF DEATH* was as follows:

Pneumonia, acute terminal(Duration) *1* yrs. *1* mos. *1* da.CONTRIBUTORY
(Secondary)*none*(Signed) *E. A. Batten* M. D.*June 22 1915* (Address) *J. H. Hopk*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2 1/2* yrs. *5* mos. *9* da. In the State *1* State *5* yrs. *5* mos. *9* da.

Where was disease contracted, if not at place of death?

Former or usual residence *812 S. Grove St*

19-PLACE OF BURIAL OR REMOVAL,

1st German

DATE OF BURIAL,

June 24, 1915

20-UNDERTAKER

Peter Niclaus

ADDRESS

2046 Eastern

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86213

CERTIFICATE OF DEATH

C86213

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. 23 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.: / yrs. 10 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Aug

16, 1915

(Month)

(Day)

(Year)

7-AGE

1 yrs. 10 mos. 5 ds.

IF LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or country)

MD. (Balto City)

10-NAME OF FATHER

Jno. P. Rennie

11-BIRTHPLACE OF FATHER

(State or country)

MD.

12-MAIDEN NAME OF MOTHER

Mamie Martin

13-BIRTHPLACE OF MOTHER

(State or country)

MD.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jno. P. Rennie

(Address)

8 W. B. Barney

15.

JUN 22 1915

HARRY O. ANDREWS,

Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 21, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY. That I attended deceased from June 14, 1915, to June 21, 1915, that I saw him alive on June 21, 1915, and that death occurred, on the date stated above, at 11:50 p.m. The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) yrs. 10 mos.

Contributory (SECONDARY)

Exhaustion

(Duration) yrs. 2 mos.

(Signed) Frank C. Ferguson, M. D.
6/21, 1915 (Address) 1230 S. Chas.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Hill Cemetery

June 23, 1915

20-UNDERTAKER

ADDRESS

H. M. L. L. L.

1422 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86214

C86214

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1224 W. Lombard* ST.; *18* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1224 W. Lombard* St.; *46* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Dec

(Month)

15, *1868*

(Day)

(Year)

7-AGE,

50 yrs., *6* mos., *7* da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

None

9-BIRTHPLACE,

(State or Country),

Pennsylvania

10-NAME OF FATHER,

Francis M. Buddy

11-BIRTHPLACE OF FATHER

(State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Elizabeth Riddamacher

13-BIRTHPLACE OF MOTHER

(State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *B. D. Buddy*(Address) *1224 W. Lombard*

15-

JUN 22 1915

HARRY V. A. [illegible]

Filed

1915 Serial Permit 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 22, *1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 7*, *1915*, to *June 22*, *1915*, that I saw her alive on *June 21*, *1915*, and that death occurred, on the date stated above, at *8:15* a.m.

The CAUSE OF DEATH* was as follows:

Chloroform & Drowning
Accidental Drowning(Duration) *2* yrs., *2* mos., *2* da.

CONTRIBUTORY (Secondary)

(Duration) *2* yrs., *2* mos., *2* da.(Signed) *F. N. Tamm*, M. D.*June 22, 1915* (Address) *317 N. Carrollton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

New Cathedral

DATE OF BURIAL

June 24, *1915*

20-UNDERTAKER

Joseph L. Cook

ADDRESS

1003 N. E. [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86215

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86215

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

On the street,

CITY OF BALTIMORE (No. Reisterstown Road & Kate Ave. 19 WARD)

2-FULL NAME

James Richard H. Hyland,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1729 McHenry street,

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male,

4-COLOR OR RACE,

White,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married,

6-DATE OF BIRTH,

September 16th, 1855.
(Month) (Day) (Year)

7-AGE,

59 yrs. 9 mos. 5 da.

If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Day laborer.
(b) General nature of industry, business, or establishment in which employed (or employer). Street work.

9-BIRTHPLACE,

(State or Country), Maryland,

10-NAME OF FATHER,

Thomas Hyland,

11-BIRTHPLACE OF FATHER

(State or Country), Maryland,

12-MAIDEN NAME OF MOTHER

Elizabeth Grant,

13-BIRTHPLACE OF MOTHER

(State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sylvia Baird, daughter,

(Address) 1729 McHenry street.

15 JUN 22 1915

HARRY O. ANDREWS,

Filed..... 191

Marial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 21st, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Sclerosis Coronary arteries.

..... (Duration) yrs. mos. ds.

CONTRIBUTORY Arterio-sclerosis, (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) J. Frederick Hempel, M. D. (Coroner.)

June 22, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs. mos. da. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mesley Chapel June 23 1915

20-UNDERTAKER

ADDRESS

Joseph B. Cook 1003 W. Balg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *8*)

2-FULL NAME

(Residence in Baltimore: No. *112 S. Euter*)

ST. *3*

WARD

REGISTERED NO. C. *53*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

St. *5* yrs. *5* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
Widow

6-DATE OF BIRTH

June

(Month)

(Day)

1855
(Year)

7-AGE

60

Yrs.

Mos.

Ds.

Or

Min.?

If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE
(State or country)

Russia

10-NAME OF FATHER

Markov

11-BIRTHPLACE OF FATHER
(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Markov

13-BIRTHPLACE OF MOTHER
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Leur's

1419 E. Baltimore St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 19, 1915, to June 23, 1915,

that I saw her alive on *June 23, 1915,*

and that death occurred, on the date stated above, at *3 a.m.*

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Leukemia
Acute periostitis of Rt. Tibial Fibula

Contributory
(SECONDARY)

Terminal Lobar Pneumonia (Rt. Lobe)
(Duration) yrs. *1* mos. *4* ds.

(Signed)

6/23, 1915 (Address) *Hebrew Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. *1* mos. *4* ds. In the State yrs. *1* mos. *4* ds.

Where was disease contracted, if not at place of death? *112 S. Euter St.*

Former or usual residence *112 S. Euter*

19-PLACE OF BURIAL OR REMOVAL

Hebrew Rosedale

DATE OF BURIAL

June 23, 1915

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Baltimore St.

18 JUN 23 1915

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1709 Belt* ST. *2nd* WARD)2-FULL NAME *Catherine Walker*(Residence in Baltimore: No. *1709 Belt St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE, *White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *6 22 1915*

(Month)

(Day)

(Year)

7-AGE,

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None.*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balti City*10-NAME OF FATHER, *Gerhard H. Walker*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Mary Richard*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Gerhard H. Walker*(Address) *1709 Belt St.*

15-

JUN 23 1915

ROBERT KRAUTER

S. 121 Kermitt Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *6 24 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *6:22* 1915, to *6:24* 1915,that I saw him alive on *6/22* 1915,and that death occurred, on the date stated above, at *4 a* m.

The CAUSE OF DEATH* was as follows:

Exhaustion
(Ind. 2 min.) (Duration) yrs. mos. ds.CONTRIBUTORY (Secondary) *Dyspepsia*

(Duration) yrs. mos. ds.

(Signed) *L. J. Burleigh* M. D.*6/22* 1915 (Address) *102 E. Fort St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cathedral Cem.*DATE OF BURIAL, *June 23 1915*20-UNDERTAKER *E. B. Naylor*ADDRESS *115 E. West St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86218

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86218

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 534 Dolphin ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 534 Dolphin St St. 5 yrs. 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Caucasian

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

June 21 (Month) 1 (Day) 1915 (Year)

7-AGE

about 56 yrs. 0 mos. 0 ds.

If LESS than 1 day, hrs. 0 min. 0

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

hair

9-BIRTHPLACE
(State or country)

Virginia

10-NAME OF FATHER

William Johnson

11-BIRTHPLACE OF FATHER
(State or country)

VA

12-MAIDEN NAME OF MOTHER

Wm. T. Keane

13-BIRTHPLACE OF MOTHER
(State or country)

VA

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Johnson

(Address)

534 Dolphin St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

6 (Month) 23 (Day) 1915 (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 21, 1915, to June 22, 1915,

that I saw him alive on June 22, 1915,

and that death occurred, on the date stated above, at 2.0 m.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. 0 mos. 2 ds.

Contributory
(SECONDARY)

arteriosclerosis

(Duration) yrs. 2 mos. 0 ds.

(Signed)

J. E. Johnson M. D.

June 22, 1915 [Address] 1212 N. 1st St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. 0 mos. 0 ds. In the State yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John's Cemetery

June 24, 1915

20-UNDERTAKE

ADDRESS

J. E. Johnson

1212 N. 1st St

15-

JUN 23 1915

ROBERT KRAUTER

Surgeon General

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86219

CERTIFICATE OF DEATH.

119
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2226 E. Oliver St.

ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph I. Lowe

(Residence in Baltimore: No. 2226 E. Oliver St.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May 6th., 1879
(Month) (Day) (Year)

7-AGE,

36 yrs. 1 mos. 15 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Thomas Lowe

11-BIRTHPLACE OF FATHER

(State or Country),

New York

12-MAIDEN NAME

13-OF MOTHER

Hannah Keneally

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caroline E. Lowe

(Address) 2226 E. Oliver St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb 5, 1915, to June 21, 1915,

that I saw him alive on June 19, 1915,

and that death occurred, on the date stated above, at 3:15 m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

Dysania

(Duration) yrs. 2 mos. ds.

(Signed) M. J. McElroy M. D.

June 22, 1915 (Address) 3042 Hudson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Ave June 24, 1915

20-UNDERTAKER,

ADDRESS

Chas. T. Evans & Son 118 Mount Royal Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 23 1915

ROBERT KRAUTER

Filed JUN 23 1915

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. 403* ST.; *1* WARD)

2-FULL NAME

(Residence in Baltimore: No. *2905' Eastern ave* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *single*
(Write the word.)

6-DATE OF BIRTH,

Unknown, *18* (Month) *18* (Day) *18* (Year)

7-AGE,

48 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer). *37 DAY*

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Welsh*(Address) *2905' Eastern Ave*

15-

JUN 23 1915 *ROBERT KRAUTER*
Filed..... 191..... *3rd* Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June *22*, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 18' 1915* to *June 22 1915*, that I saw him alive on *June 22 1915*, and that death occurred, on the date stated above, at *3:15 a* m.

The CAUSE OF DEATH* was as follows:

Suppurative appendicitis
operated on June 16 1915
(Duration) yrs. mos. ds. *10*

CONTRIBUTORY (Secondary)

(Signed) *Geo H. Snare* M. D.
6/22 191*5* (Address) *Franklin Sq. 403*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *7* ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? *at home*Former or usual residence *2905' Eastern Ave*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

WHITE PLAIN, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86221

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

63+

C86221

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *631 Brice St.* ST. *16* WARD)

2-FULL NAME *Elmer Richard Seabreeze*

Residence in Baltimore: No. *631 Brice St.*

Str.: yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and full out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

May 30, 1913
(Month) (Day) (Year)

7-AGE

2 yrs. *21* mos. *21* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9-BIRTHPLACE (State or country)

Baltimore City

10-NAME OF FATHER

Elmer Seabreeze

11-BIRTHPLACE OF FATHER (State or country)

Baltimore City

12-MAIDEN NAME OF MOTHER

Agnes Holzman

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Adam Holzman

(Address)

631 N Brice St

15.

JUN 23 1915

ROBERT . KRAUTER,

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 21, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from

June 19, 1915, to, *June 21, 1915*.

that I saw him alive on *June 20, 1915*.

and that death occurred, on the date stated above, at *10.30 A.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Polio myelitis

(Duration) yrs. mos. *3* ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

Robert H. Murray M. D.

June 22, 1915 (Address) *510 N. Fremont St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Alphonsus Church

DATE OF BURIAL

June 23, 1915

20-UNDERTAKER

John J. Fields 1207 N. Lombard St

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *8* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1629 St Joseph St* St. *8* yrs. *10* mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

Aug *?* *1914*
(Month) (Day) (Year)

7-AGE.

10 yrs. *10* mos. *10* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*child*9-BIRTHPLACE,
(State or Country).*Ind.*

PARENTS.

10-NAME OF FATHER.

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country).*Unknown*

12-MAIDEN NAME OF MOTHER

*Kate Palmer*13-BIRTHPLACE OF MOTHER
(State or Country).*Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. B. Curry*(Address) *Johns Hopkins*

15 JUN 23 1915

ROBERT J. KRAUTER,

Filed..... 191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June *21* *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 20* 1915, to *June 21* 1915, that I saw him alive on *June 21* 1915, and that death occurred, on the date stated above, at *11 1/2* m.

The CAUSE OF DEATH* was as follows:

Inhalation, Abnormal
(Duration) *1* yrs. *10* mos. *10* ds.CONTRIBUTORY *None*
(Secondary)(Duration) *1* yrs. *10* mos. *10* ds.(Signed) *G. G. Batten* M. D.*June 21* 1915. (Address) *1629 St Joseph St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *10* mos. *10* ds. In the State *10* yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1629 St Joseph St*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Laurel Cemetery *June 24* 1915

20-UNDERTAKER

ADDRESS

Harry A. Voday *1725 Orleans St*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86223

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86223

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1713 W. Franklin* ST.; *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary A. Rosenthal*
(Residence in Baltimore: No. *1713 W. Franklin* St.; *34* yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, *Married*, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, *Feb.* *22*, *1868*
(Month) (Day) (Year)

7-AGE, *47* yrs., *5* mos., ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer). *Her own household work*

9-BIRTHPLACE, (State or Country), *Elkridge Md.*

PARENTS.
10-NAME OF FATHER, *John Downey*
11-BIRTHPLACE OF FATHER (State or Country), *Elkridge Md.*
12-MAIDEN NAME OF MOTHER *Jane Young*
13-BIRTHPLACE OF MOTHER (State or Country), *Elkridge Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Helen Jones*
(Address) *1713 W. Franklin St.*

15-

Filed *JUN 23 1915* 1915. ROBERT KRAUSE, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June* *22*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 18* - *1915*, to *June 22* - *1915*, that I saw her alive on *June 21* - *1915*, and that death occurred, on the date stated above, at *2:45* a. m. The CAUSE OF DEATH* was as follows:

Initial insufficiency with cardiac hypertrophy
(Duration) *9* yrs., *6* mos., ds.

CONTRIBUTORY *acute parenchymatous nephritis* (Secondary)
(Duration) *2* yrs., mos., *5* ds.
(Signed) *Chas. C. McFarley* M. D.
June 22, 1915 (Address) *906 E. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Elkridge Md.* DATE OF BURIAL, *June 24, 1915*

20-UNDERTAKER *Wm. Tucker Sons* ADDRESS *North & Pa*
By Motor

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86224

CERTIFICATE OF DEATH

43

C86224

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1121 N. Fulton Ave.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and full out No. 18.)

2 FULL NAME

Laura Virginia Hopwood

(Residence in Baltimore: No. 1121 North Fulton St.)

Sr.: 1 yrs. 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

April 17, 1851

7 AGE

64 yrs. 2 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

William C. Blaeriston

11 BIRTHPLACE OF FATHER (State or country)

Augusta, Maryland

12 MAIDEN NAME OF MOTHER

Elizabeth Torlinson

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. M. Perry
(Address) 1023 N. Gilman St.

15

Filed JUN 23 1915

ROBERT K. BRADY
BUTLER PARK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 20, 1915

17 I HEREBY CERTIFY That I attended deceased from March 1912 to June 20, 1915.

that I saw her alive on June 20, 1915; and that death occurred, on the date stated above, at 8 p. m. The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 3 yrs. 3 mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) H. M. Perry M. D.
June 22, 1915 (Address) 1023 N. Gilman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Louisa, Md.

DATE OF BURIAL

June 24, 1915

20 UNDERTAKER

W. J. Siskind

ADDRESS

North

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86225 CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *Mercy Hospital* ST. *13* WARD)2-FULL NAME *James A. Brown*(Residence in Baltimore: No. *22 Berry St.* St.; yrs., mos. da.)

(If death occurred in a hospital or institution, give its NAME, number of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) *Single*6-DATE OF BIRTH *Not known*

(Month)

(Day)

(Year)

7-AGE *38*

yrs. mos. da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Librarian*(b) General nature of industry, business, or establishment in which employed (or employer) *City*9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *Not known*11-BIRTHPLACE OF FATHER (State or Country), *"*12-MAIDEN NAME OF MOTHER *"*13-BIRTHPLACE OF MOTHER (State or Country), *"*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert M. Kratter*(Address) *Calvert St.*

15-

Filed

JUN 23 1915

ROBERT M. KRATTER

Burial Permit Clerk

Registrar.

19-PLACE OF BURIAL OR REMOVAL,

COLLEGE OF P. & S

DATE OF BURIAL,

JUN 23 1915

20-UNDERTAKER

ADDRESS

Commissioner Health.

Per. Wm. E. WOODALL.

FOR ANATOMICAL PURPOSES

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND,)
) To Wit:
CITY OF BALTIMORE,)

I HEREBY CERTIFY, that on this 4th day of August, 1915, before me, the subscriber, a Notary Public of the State of Maryland, in and for Baltimore County, personally appeared Edward P. Smith, M. D. and made oath in due form of law that the certificate of death of James A. Brandon, who died at the Mercy Hospital, June 21, 1915, should be and is that of James A. Brown, and that the name James A. Brandon was placed thereon in error.

WITNESS my hand and Notarial Seal.

O. Parker Baker
Notary Public.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1013 N. Vincent street, St. 16 WARD)

2-FULL NAME

Edward Butler,

(Residence in Baltimore: No. 1013 N. Vincent street,

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male,

4-COLOR OR RACE,

Colored,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single,

6-DATE OF BIRTH,

May 7th, 1913.

(Month)

(Day)

(Year)

7-AGE,

2 yrs. 1 mos. 8 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

None,

9-BIRTHPLACE,
(State or Country),

Baltimore, Md.

10-NAME OF
FATHER,

Charles H. Butler,

11-BIRTHPLACE
OF FATHER
(State or Country),

Maryland,

12-MAIDEN NAME
OF MOTHER

Lizzie Young,

13-BIRTHPLACE
OF MOTHER
(State or Country),

Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H. Butler, father,

(Address) 1013 N. Vincent street.

15-

JUN 23 1915

ROBERT

K. BAYLES

Filed..... 191..... Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 21st, 1915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-

...inquiry and that said deceased came to his death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY Bad hygienic surround-...

ings, (Signed) Frederick Hempel M. D.

(Coroner.)

June 22, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

HOPKINS HOSPITAL

JUN 23 1915

20-UNDERTAKER

ADDRESS

Commissioner Health.

FOR ANATOMICAL PURPOSES.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED,
WIDOWED,
OR SEPARATED,
(If married, give the word.)

6-DATE OF BIRTH

7-AGE

If less than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country).10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country).12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

HARRY O. ANDREWS

Marital Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

from 21 1915, to from 22 1915,

that I saw him alive on from 22 1915,

and that death occurred, on the date stated above, at 7:50 a. m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(Duration)....yrs....mos....da.

CONTRIBUTORY
(Secondary)

(Duration)....yrs....mos....da.

(Signed) John W. Henderson M. D.

from 22, 1915. (Address) 1714 N. Lee Ave. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
IENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cem.

June 24, 1915

20-UNDERTAKER

ADDRESS

Philip Seewald & Son 119 S. Eutaw St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *Balti. Exp. Care Throat Hosp. St.* 3 WARD)

FULL NAME *Mrs. Bertha Coulbourne*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. *2016 E. Lombard St.* St. *34* yrs. *11* mos. *13* ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word)

6. DATE OF BIRTH *July 9, 1880*
(Month) (Day) (Year)

7. AGE *34* yrs. *11* mos. *13* ds. or — min. ?
17 LESS than 1 day, — hrs.

8. OCCUPATION *Housework*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country) *Baltimore City*

10. NAME OF FATHER *A. C. Messick*

11. BIRTHPLACE OF FATHER (State or country) *Maryland*

12. MAIDEN NAME OF MOTHER *Mary Harrington*

13. BIRTHPLACE OF MOTHER (State or country) *Maryland*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Clarence Coulbourne*
(Address) *2016 E. Lombard St.*

15. JUN 23 1915 HARRY O. ANDREAS, REGISTRAR
Filed, 191

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *June 22, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 17, 1915* to *June 22, 1915*.
that I saw him alive on *June 22, 1915*.
and that death occurred, on the date stated above, at *4 P.* m.
The CAUSE OF DEATH* was as follows:

Cerebral abscess

Contributory (SECONDARY) *Ch. Suppurative Otitis Media*
(Duration) *2* yrs. — mos. — ds.

(Signed) *Jesse L. Horney, Jr.* M. D.
June 22, 1915 (Address) *529 W. Charles St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. *7* ds. State *34* yrs. *11* mos. *13* ds.
Where was disease contracted, if not at place of death?
Former or usual residence *2016 E. Lombard St.*

19. PLACE OF BURIAL OR REMOVAL *Mt. Carmel An.* DATE OF BURIAL *June 23, 1915*

20. UNDERTAKER *Geo M. Finner* ADDRESS *8117 Wolfe*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86229

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86229

CERTIFICATE OF DEATH

28

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. *103 S. Catherine* ST. *20* WARD)

2-FULL NAME *Frederick Martin Hausmann*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No. *103 S. Catherine St.* St. *37* yrs. *6* mos. *17* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE MARRIED *Married* WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH *Dec 4* 1877 (Month) (Day) (Year)

7-AGE *37* yrs. *6* mos. *17* ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work *Clothing Cutter* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Balto.*

PARENTS 10-NAME OF FATHER *Conrad Hausmann* 11-BIRTHPLACE OF FATHER (State or country) *Germany* 12-MAIDEN NAME OF MOTHER *Catherine Weyfath* 13-BIRTHPLACE OF MOTHER (State or country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Anna Hausmann* (Address) *103 Catherine St*

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *June 22*, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *June 1*, 1915, to *June 22*, 1915, that I saw him alive on *June 21*, 1915, and that death occurred, on the date stated above, at *8 a.* m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory (SECONDARY)

(Signed) *E. J. Dickey* M. D. *June 22*, 1915. [Address] *14 N. Monroe St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

16-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park

June 24, 1915

17-UNDERTAKER

ADDRESS

Geo. L. Schmitt & Son 2101 E. Pratt St.

JUN 23 1915 HARRY O. ANDREWS, REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86230

64 C86230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2419 C Chase* ST.: *8* WARD)2-FULL NAME *Charlotte Pfarr*(Residence in Baltimore: No. *2419 C Chase* St.: *53* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)6-DATE OF BIRTH *Not known*

(Month) (Day) (Year)

7-AGE *53*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER *William Nash*11-BIRTHPLACE OF FATHER (State or Country) *England*12-MAIDEN NAME OF MOTHER *Elizabeth Benley*13-BIRTHPLACE OF MOTHER (State or Country), *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph J. Pfarr*(Address) *2419 C Chase St*

15-

JUN 23 1915

HARRY O. ANDREWS,

Filed....., 1915. *Marial. Permlt. Olerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 23, 1915*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 16, 1915*, to *June 23, 1915*, that I saw h *ex* alive on *June 23, 1915*, and that death occurred, on the date stated above, at *6:30 P.m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration).....yrs.....mos.....7.....ds.

CONTRIBUTORY *Probably nephritis*
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *H. Austin Decker* M. D.*June 26, 1915.* (Address) *2350 E. Baltimore St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cem.*DATE OF BURIAL, *June 26, 1915*20-UNDERTAKER *Frank Crockett*ADDRESS *1924-6 Ashland*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hosp* ST.; *7* WARD)2-FULL NAME *John Builder*(Residence in Baltimore: No. *1010 Sheridan Rd. Evanston Ill.* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

May 4, 18*65*
(Month) (Day) (Year)

7-AGE,

50 yrs. *1* mos. *20* ds.If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Canada

10-NAME OF FATHER,

John Builder

11-BIRTHPLACE OF FATHER (State or Country),

Canada

12-MAIDEN NAME OF MOTHER,

Grace Fullerton

13-BIRTHPLACE OF MOTHER (State or Country),

Canada

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *A. B. Curry*(Address)..... *1010 Sheridan Rd. Evanston Ill.*15- *JUN 24 1915*
Filed....., 191.....
TOBERT V. KRAUTER,
Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 26* 191*5*, to *June 24* 191*5*, that I saw him alive on *June 24* 191*5*, and that death occurred, on the date stated above, at *6.9* m. The CAUSE OF DEATH* was as follows:*Maemia*(Duration)..... yrs. mos. *20* ds.CONTRIBUTORY (Secondary)..... *Chronic hepatitis*

(Duration)..... yrs. mos. ds.

(Signed)..... *F. Janner Smith* M. D.*June 24*, 191*5*. (Address) *Johns Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. *28* ds. In the State..... yrs. mos. *28* ds.Where was disease contracted, if not at place of death? *✓*Former or usual residence..... *1010 Sheridan Rd. Evanston Ill.*

19-PLACE OF BURIAL OR REMOVAL,

Chicago Ill

DATE OF BURIAL,

June 24, 191*5*

20-UNDERTAKER

Albert C. Fuller

ADDRESS

221 N. Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hahnemann San Hospital* REGISTERED NO. C.
 CITY OF BALTIMORE: (No. *11277 Mount St.* ST. *15* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME *Thongo Webb*
 (Residence in Baltimore: No. *1806 Laurens* St. *Unknown* yrs. *Unknown* mos. *Unknown* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Colored* 5-SINGLE, *Single* MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
 6-DATE OF BIRTH, *Unknown*, 1891 (Month) (Day) (Year)
 7-AGE, *24* yrs. *Unknown* mos. *Unknown* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, *Laborer*
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *William Webb*
 11-BIRTHPLACE OF FATHER (State or Country), *Maryland*
 12-MAIDEN NAME OF MOTHER, *Mary Catherine Smith*
 13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *Mary Webb*
 (Address) *1451 W. Mount St.*

15- *JUN 24 1915* ROBERT KRAUTER, Registrar.
 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 23, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 9th* 1915, to *June 23rd* 1915, that I saw him alive on *June 20th* 1915, and that death occurred, on the date stated above, at *6:30* m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope
 (Duration).....yrs.....mos. *14* ds.
 CONTRIBUTORY *Typhoid Fever*
 (Secondary)
 (Duration).....yrs.....mos. *Unknown* ds.
 (Signed) *Geo. E. Coughlin* M. D.
June 23, 1915 (Address) *205 E. Enoch St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
 At place of death.....yrs.....mos. *14* ds. In the State *24* yrs.....mos. *Unknown* ds.

Where was disease contracted, if not at place of death? *Unknown*
 Former or usual residence *1806 Laurens St.*

19-PLACE OF BURIAL OR REMOVAL, *Mt Auburn* DATE OF BURIAL, *June 27, 1915*

20-UNDERTAKER, *James H. Dennis* ADDRESS *1303 Bystown*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2014 E. Eager ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2014 E. Eager St.; 8 yrs. 1 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Married

6-DATE OF BIRTH.

May 31, 1849
(Month) (Day) (Year)

7-AGE,

66 yrs. 1 mos. 22 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).At home9-BIRTHPLACE,
(State or Country),Baltimore

PARENTS.

10-NAME OF FATHER,

Wm. Allard11-BIRTHPLACE OF FATHER
(State or Country),England

12-MAIDEN NAME OF MOTHER

Sarah Cole13-BIRTHPLACE OF MOTHER
(State or Country),U. S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Alice A. Wamsley

(Address)

2014 E. Eager

15-JUN 24 1915.

ROBERT KRAUTH

Filed..... 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 22, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 15 1915, to June 22 1915, that I saw her alive on June 22 1915, and that death occurred, on the date stated above, at 2:35 P. m.

The CAUSE OF DEATH* was as follows:

Bright Disease(Duration)..... yrs. 4 mos. ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... M. D.

June 23, 1915 (Address) 1531 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Greenmount June 23, 1915

20-UNDERTAKER

ADDRESS

Fiskler, Fiskler E. Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86234

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 C86234

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 44 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6 DATE OF BIRTH

Unknown

1834

7 AGE

81

yrs.

mos.

ds.

If LESS than 1 day, — hrs. or — min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

Md

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis B. Cromwell

(Address)

422 W. Cross St

15.

JUN 24 1915

ROBERT J. BRANTER

Chief Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June

22nd, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1915, to June 22nd, 1915, that I saw him alive on June 21, 1915, and that death occurred, on the date stated above, at 2a. m. The CAUSE OF DEATH* was as follows:

Pneumonia, double

Contributory (SECONDARY) Heart Paralysis (Duration) yrs. 12 mos. 12 ds

(Signed) L. H. Hoffman M. D. June 22, 1915 (Address) No 27 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds. Where was disease contracted, if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Mt. Auburn

DATE OF BURIAL

June 24, 1915

20 UNDERTAKER

John H. Toadum

ADDRESS

142 W. Hill St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *4* WARD)2-FULL NAME *Benton Martin*(Residence in Baltimore: No. *Bigger Otter U. Va.* St. *4* yrs. *6* mos. *11* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

Dec 10, 1888
(Month) (Day) (Year)

7-AGE,

26 6 11
yrs. mos. ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Painter*

9-BIRTHPLACE,

(State or Country),

U. Va.

10-NAME OF FATHER,

Trinity Martin

11-BIRTHPLACE OF FATHER

(State or Country),

U. Va.

12-MAIDEN NAME OF MOTHER

Phame Fugate

13-BIRTHPLACE OF MOTHER

(State or Country),

U. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Record Mercy Hosp*(Address) *Calvert St.*

15-

JUN 24 1915

ROBERT . KRATERS

191..*24*..*12*..*Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 21, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 29, 1915 to *June 21, 1915*that I saw him alive on *June 21, 1915*and that death occurred, on the date stated above, at *7:30 P.*

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Myelitis
Exhaustion
(Duration) *1* yrs. *6* mos. *11* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. *6* mos. *11* ds.(Signed) *Edward J. Smith, M. D.**June 21, 1915* (Address) *Mercy Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *13* yrs. *6* mos. *11* ds. In the State *23* yrs. *6* mos. *11* ds.Where was disease contracted, if not at place of death? *Bigger Otter U. Va.*Former or usual residence *Bigger Otter U. Va.*19-PLACE OF BURIAL OR REMOVAL, *JUN 23 1915*

HOPKINS HOSPITAL

20-UNDERTAKER

Commissioner Health.

ADDRESS

FOR ANATOMICAL PURPOSES

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86236

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital*)ST.: *15* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *2407 Garrison Ave*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *40* yrs. *8* mos. *18* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

IF LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert M. Hays*(Address) *Calvert St.*

15-

Filed *JUN 24 1915*ROBERT M. HAYS
Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) *June*, 191*5* (Day) *23* (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 23 1915*, to *June 23 1915*, that I saw her alive on *June 23 1915*, and that death occurred, on the date stated above, at *4 p.m.*

The CAUSE OF DEATH* was as follows:

Pregnancy at term, multiple, ruptured 9 cervix, placenta
(Duration) *9* yrs. *8* mos. *18* da.CONTRIBUTORY
(Secondary)(Duration) *9* yrs. *8* mos. *18* da.(Signed) *Edward J. Smith* M. D.
June 23 1915 (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *23* yrs. *8* mos. *18* da. In the State *Life* mos. *18* da.Where was disease contracted, if not at place of death? *2407 Garrison Ave*Former or usual residence *2407 Garrison Ave*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

79

C86237

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Residence in Baltimore: No.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6 DATE OF BIRTH July 16, 1890 (Month) (Day) (Year)

7 AGE 24 yrs. 11 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Spinner Cotton Duck

9 BIRTHPLACE (State or country)

Baltimore

10 NAME OF FATHER

Charles Sparr

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Marx

13 BIRTHPLACE OF MOTHER (State or country)

Balti. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

JUN 24 1915

Filed

191

Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 23, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from about May 4, 1915, to June 23, 1915, that I saw her alive on June 19, 1915, and that death occurred, on the date stated above, at 11:30 A.M. The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Contributory (SECONDARY)

Central embolism

(Signed)

June 23, 1915

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86233

64 C86233

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *308 E 21st* St. *12* WARD)
2-FULL NAME *Henry Tiemann*
(Residence in Baltimore: No. *308 E 21st* St. yrs. mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*
4-COLOR OR RACE, *white*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Unknown*
6-DATE OF BIRTH, *Nov - 1830*
(Month) (Day) (Year)
7-AGE *84* yrs. *7* mos. ds.
If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), *Germany*
10-NAME OF FATHER, *Unknown*
11-BIRTHPLACE OF FATHER (State or Country), *Unknown*
12-MAIDEN NAME OF MOTHER, *Unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Dora Cronwell*
(Address) *308 E. 21st*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 23, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Arterio Sclerosis*
(Duration) yrs. mos. ds.
(Signed) *Henry E. Regis* M. D.

June 23, 1915 (Address) *308 E. 21st*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER ADDRESS

15-

JUN 24 1915

ROBERT KRAUTER,

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2317 E. Lafayette Ave. 6 ST. 6 WARD)

2-FULL NAME

William Britton Ebenezer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2317 E. Lafayette Ave. St.; 7 yrs., 7 mos., 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Married

6-DATE OF BIRTH

March 2(Month) 3 (Day) 2 (Year) 1835

7-AGE

803 yrs., 7 mos., 7 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Farmer

9-BIRTHPLACE,

(State or Country),

Luray Va

10-NAME OF FATHER

Thomas

11-BIRTHPLACE OF FATHER

(State or Country),

Luray Va

12-MAIDEN NAME OF MOTHER

Rebecca Groun

13-BIRTHPLACE OF MOTHER

(State or Country),

Luray Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. M. Shuck(Address) 2317 E. Lafayette Ave.

15-

JUN 24 1915ROBERT KRAUTER9101 7th St. N.W.Bureau of Vital Records

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June

(Month)

23

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 14 1914, to June 23 1915,that I saw him alive on June 23 1915,and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) 6 yrs., 6 mos., 6 ds.

CONTRIBUTORY (Secondary)

Senile Degeneration(Duration) 6 yrs., 6 mos., 6 ds.(Signed) W. C. Sandrock M. D.June 23, 1915 (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs., 7 mos., 7 ds. In the State 7 yrs., 7 mos., 7 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Compton Va

DATE OF BURIAL

June 26, 1915

20-UNDERTAKER

William Cook

ADDRESS

602 E. N. Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1735 N Montford Ave St. 8

2-FULL NAME

Victoria M Lutz

(Residence in Baltimore: No. 1735 N Montford Ave

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Unmarried

6-DATE OF BIRTH,

Jan 2nd, 1914
(Month) (Day) (Year)

7-AGE,

1 yrs. 5 mos. 21 ds.

IF LESS than 1 day,
...hrs. ormin.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE,
(State or Country),

Mo

10-NAME OF FATHER,

Lawrence Lutz

11-BIRTHPLACE OF FATHER
(State or Country),

N. Y.

12-MAIDEN NAME OF MOTHER

Mary Karle

13-BIRTHPLACE OF MOTHER
(State or Country),

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lawrence Lutz

(Address)

1735 N Montford Ave

JUN 24 1915

ROBERT KRAUTER,

Filed

191

BURIAL PERMIT CLARK

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Complications

(Duration) yrs. mos. ds.

(Signed)

Chas. H. Kessel M. D.
(Coroner.)

June 24, 1915 (Address) 423 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

June 25 1915

20-UNDERTAKER

Wendell D. Dyer 328 N

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

C86241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *Med. Gen. Hosp.* ST. *24* WARD)
2-FULL NAME *Mrs. Mary Mobery*
(Residence in Baltimore: No. *513 E. Clement* St.; — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE. <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Widow</i> (Write the word.)
6-DATE OF BIRTH. <i>Unknown</i> , 1..... (Month) (Day) (Year)		
7-AGE. <i>70</i> yrs. mos. ds.		8-LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>None</i> (b) General nature of industry, business, or establishment in which employed (or employer)		
9-BIRTHPLACE. (State or Country), <i>Worcester Co. Md.</i>		
PARENTS.	10-NAME OF FATHER. <i>Aaron Ringrose</i>	
	11-BIRTHPLACE OF FATHER. (State or Country), <i>Md.</i>	
	12-MAIDEN NAME OF MOTHER. <i>Cutler Lacey</i>	
	13-BIRTHPLACE OF MOTHER. (State or Country), <i>Md.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Ringrose*
(Address) *513 Clement St.*

15-
JUN 24 1915
191. *HARRY O. ANDREWS*
Burial Permit Officer
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,
June 24, 191*5*.
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I attended deceased from *April 16* 191*5*, to *June 24* 191*5*, that I saw her alive on *June 24* 191*5*, and that death occurred, on the date stated above, at *1 P. m.*
The CAUSE OF DEATH* was as follows:
Malignancy of Uterus (Carcinoma)
(Duration) *3* yrs. *2* mos. *8* ds.
CONTRIBUTORY *Senility*
(Secondary)
(Duration) *3* yrs. *7* mos. *7* ds.
(Signed) *David Street* M. D.
June 24 191*5*. (Address) *712 Park Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. *2* yrs. *8* mos. *8* ds. In the State *70* yrs. — mos. — ds.

Where was disease contracted, if not at place of death? *?*

Former or usual residence *513 E. Clement St.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Vincent Cemetery *June 24*, 191*5*.

20-UNDERTAKER, ADDRESS

Geo. B. Cook *1003 E. Baltimore St.*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86242

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86242

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 605 N. Carey ST. 16 WARD)

2-FULL NAME Thomas Doulan (Donlan)

Residence in Baltimore: No. 605 N. Carey St. St. 16 yrs. — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED widower
(Write the word)

6-DATE OF BIRTH April 10, 1845
(Month) (Day) (Year)

7-AGE 70 yrs. 2 mos. 12 ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Retired Baker
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Haverd Grace Md

10-NAME OF FATHER James Doulan

11-BIRTHPLACE OF FATHER (State or country) Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas B. Doulan

(Address) 625 N. Carey St

15. JUN 24 1915

HARRY O. ANDREWS,
Morial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH June 22, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1915, to June 22, 1915, that I saw him alive on June 22, 1915, and that death occurred, on the date stated above, at 70 m. The CAUSE OF DEATH* was as follows:

arteriosclerosis

(Duration) 2 yrs. — mos. — ds

Contributory (SECONDARY) arteriosclerosis

(Duration) — yrs. — mos. — ds

(Signed) J. T. Munn M. D.
June 23, 1915 (Address) 1042 Edmond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

New Cathedral DATE OF BURIAL June 25, 1915

20-UNDERTAKER

Henry Branningshaw ADDRESS 517 N. Schroeder St

C86243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

183 C86243
REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *Mary Hospital* ST. *12* WARD)2-FULL NAME *Nie Daturi*(Residence in Baltimore: No. *1806 Maryland Ave* St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

May 15, 1897
(Month) (Day) (Year)

7-AGE,

18 yrs. *1* mos. *6* ds.If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Laborer*9-BIRTHPLACE,
(State or Country).*Italy*

10-NAME OF FATHER,

Pete Daturi

11-BIRTHPLACE OF FATHER

(State or Country), *Italy*

12-MAIDEN NAME OF MOTHER

Concetta Macerino

13-BIRTHPLACE OF MOTHER

(State or Country), *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Pete Daturi*(Address) *1806 Maryland Ave*

15-

JUN 24 1915

Filed

191

HARRY O. ANDREWS,

Marial Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 21, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide
suicidal wound of neck
by some sharp instrument
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Thos. H. Hamer* M. D.
(Coroner.)*June 23, 1915* (Address) *1806 Maryland Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *18 minutes* In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1806 Maryland Ave*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 3755 Morley ST.; 15 WARD)2 FULL NAME Edward R Poole(Residence in Baltimore: No. 3755 Morley St St.; 24 yrs., 3 mos. 14 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, March 10, 1886 (Month) (Day) (Year)7-AGE, 29 yrs., 3 mos., 14 ds. If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. Uphester (b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Balt10-NAME OF FATHER, John A Poole11-BIRTHPLACE OF FATHER (State or Country), Balt Md12-MAIDEN NAME OF MOTHER Ellen Hildner13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry O. Andrews(Address) 3755 Morley St15-JUN 24 1915 HARRY O. ANDREWS, Registrar.

Filed..... 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from here 1914, to June 22 1915, that I saw him alive on June 22 1915, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Duration) 6 Months ds.

CONTRIBUTORY (Secondary) (Duration)..... yrs..... mos..... ds.

(Signed) Harold W Jones M. D. June 23, 1915. (Address) 222 August St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, June 24, 191520-UNDERTAKER Wm. C. B. Smith ADDRESS 502 E. Pratt

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86245

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86245

CERTIFICATE OF DEATH

40

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 2 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 JUN 24 1915

Filed

HARRY O. ANDERSON,

191 Serial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

April 10, 1915, to June 23, 1915.

that I saw him alive on June 23, 1915.

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Diarrhea
Carcinoma of Stomach

(Duration) 2 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) June 24, 1915 (Address) M. J. Fair

12 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mary's Cemetery June 24, 1915

20-UNDERTAKER

ADDRESS

Clemworth & Son, District Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86246

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 W. Pratt, ST.: 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna B. Hild(Residence in Baltimore: No. 334 W. Pratt St St.: 33 yrs., 1 mos., 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, SingleMarried
Widowed
Or divorced
(Write the word.)

6-DATE OF BIRTH.

May 12th, 1882
(Month) (Day) (Year)

7-AGE,

33 yrs., 1 mos., 10 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Typ. Writer

9-BIRTHPLACE,

(State or Country), Balt

PARENTS.

10-NAME OF FATHER,

Anten Hild

11-BIRTHPLACE OF FATHER

(State or Country), Germany

12-MAIDEN NAME OF MOTHER

Anna Jacober

13-BIRTHPLACE OF MOTHER

(State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. Jacober(Address) 334 W. Pratt St

15-

JUN 24 1915

HARRY O. ANDREWS,

Sanitary Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 22, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from about May 1914, to June 22 1915, that I saw her alive on June 22 1915, and that death occurred, on the date stated above, at 840 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, subacute
about 5 years (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Heart (Duration).....yrs.....mos.....ds.(Signed) J. D. Blake M. D.June 22, 1915 (Address) 111 W. Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer June 25, 1915

20-UNERTAKER

ADDRESS

Geo Limbach 677 W. Pratt St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 170

C86247

PLACE OF DEATH

CITY OF BALTIMORE (NO.

2-FULL NAME

(Residence in Baltimore: No.

Mersey Hospital

Charles Hall

Millersville. Ann Arundel Co., Md.

ST.: 4

WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

July

26th, 1898

7-AGE,

16

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

School boy

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Chas. Hall

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Martin Smith

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Martin Hall

(Address)...

Millersville, Md.

15-

JUN 24 1915

HARRY O. ANDREWS,

191. Serial Permit. Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

24th, 1915

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Gunshot wound of r. chest (penetrating 2 pleural cavities and lungs) caused by accidental explosion of a gun.

CONTRIBUTORY (Secondary)

Peritonsillitis

(Signed)...

Monroe Savage

(Coroner.)

June 24, 1915. (Address) 1729 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs... mon. 2 ds. In the 16

Where was disease contracted, if not at place of death? At Millersville, Ann Arundel Co., Md.

Former or usual residence

19-PLACE OF BURIAL OF

DATE OF BURIAL,

Millersville, Md.

June 25 1915

20-UNDERTAKER

ADDRESS

Robt J. Turner 1441 N. ...

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1813 Lorman* ST. *15* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1813 Lorman*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word)

Single

6-DATE OF BIRTH,

June 23, 1915
(Month) (Day) (Year)

7-AGE,

yrs. mos. ds.

If LESS than 1 day.

1 hr. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE,

(State or Country)

Balto. Md

10-NAME OF FATHER,

Thos. Cross

11-BIRTHPLACE OF FATHER

(State or Country)

Md

12-MAIDEN NAME OF MOTHER

Elizabeth Collins

13-BIRTHPLACE OF MOTHER

(State or Country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Nettie Sisco

(Address)

1813 Lorman St

15-

JUN 25 1915

ROBERT . KRAUTER

Bureau Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *June 23, 1915* to *June 24, 1915*, that I saw her alive on *June 24, 1915*, and that death occurred, on the date stated above, at *12:45 p.m.*

The CAUSE OF DEATH* was as follows:

Premature Birth
1 hour
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *John S. Linn* M. D.*June 24, 1915* (Address) *1507 N. E. Baltimore Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL.

St Albans *June 25, 1915*

20-UNDERTAKER

ADDRESS

James H. Davis *1903 Ruston*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH (86249)

County

Village City Baltimore

(No. Morris 2305

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. (86249)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rosie Edwards

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6 DATE OF BIRTH Mar 6 1854 (Month) (Day) (Year)

7 AGE 61 yrs 3 mos 17 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housework (b) General nature of industry business, or establishment in which employed (or employer) Home

9 BIRTHPLACE (State or country) Baltimore - Md

PARENTS 10 NAME OF FATHER George D. Bickley 11 BIRTHPLACE OF FATHER (State or country) Baltimore - Md 12 MAIDEN NAME OF MOTHER Nellie Bickley 13 BIRTHPLACE OF MOTHER (State or country) Baltimore - Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara Horn

(Address) 2305 Morris St Baltimore

15 JUN 25 1915 ROBERT KRAUTER, Mortal Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 23 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1914, to June 23 1915, that I last saw him alive on June 20 1915, and that death occurred on the date stated above, at 8 am.

The CAUSE OF DEATH * was as follows: Chronic Infectious Nephritis

(Duration) 1 yrs 6 mos 17 ds

Contributory Secondary

General Debility (Duration) 2 yrs 8 mos 17 ds (Signed) Dr. E. E. Benson, M. D. June 23 1915 (Address) Cockeysville

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENT, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Long Green Rd June 25 1915

20 UNDERTAKER ADDRESS

Charles F. Henderson 58 W. Bond

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *910 N. Wolfe* ST.; *7* WARD)FULL NAME *Mary Frances Walter*(Residence in Baltimore: No. *910 N. Wolfe* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH *Feb 14*, 18*56* (Month) (Day) (Year)7-AGE *59* yrs. *4* mos. *9* ds. If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work *None* (b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *John T. White*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Mary J Ramsay*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr J. Walter* (Address) *910 N. Wolfe St*15- *JUN 25 1915* *ROBERT KRAUTER,* *Serial Permit Clerk.* Filed..... 191*5* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *June 23rd*, 19*15* (Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 10th* 1914, to *June 23rd* 1915, that I saw h *or* alive on *June 22nd* 1915, and that death occurred, on the date stated above, at *11:45* m.

The CAUSE OF DEATH* was as follows:

Chronic Disagria
Cancer of the Stomach
(Duration)..... yrs. *11* mos. ds.

CONTRIBUTORY (Secondary)..... (Duration)..... yrs. mos. ds.

(Signed) *J. D. Stouffer* M. D. (Address) *1501 N. E. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Baltimore Cemetery *June 26, 1915*

20-UNDERTAKER ADDRESS

Henry Lutz *1007 N. Bond*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1* ST.; *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *29 S. Potomac* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH.

June 8th, 1910
(Month) (Day) (Year)

7-AGE.

5 yrs. *16* mos. *16* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE.
(State or Country).*Balti city Md.*

PARENTS.

10-NAME OF FATHER.

*Charles Hitchcock*11-BIRTHPLACE OF FATHER
(State or Country).*Balti city Md.*

12-MAIDEN NAME OF MOTHER

*Mamie Weiss*13-BIRTHPLACE OF MOTHER
(State or Country).*Balti city Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).

Charles Hitchcock

(Address).

29 S. Potomac St.

15-

Filed

JUN 25 1915

ROBERT

KRAUSE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 24, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 23, 1915*, to *June 24, 1915*, that I saw her alive on *June 24, 1915*, and that death occurred, on the date stated above, at *1200* A.M.
The CAUSE OF DEATH* was as follows:*Gangrene Appendicitis*
(Duration) ... yrs. ... mos. *2* ds.CONTRIBUTORY
(Secondary)*General Peritonitis*
(Duration) ... yrs. ... mos. *2* ds.
(Signed) *Edward J. Smith* M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. *1* yr. *2* mos. *16* ds. In the State *MD.*Where was disease contracted, if not at place of death? *29 S. Potomac St.*Former or usual residence *29 S. Potomac St.*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Oak Lane Cem. June 25, 1915

20-UNDERTAKER

ADDRESS

A. Sander Sons 170 West St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 N. Washington St.; 8 WARD)FULL NAME Adam Bitterbusch(Residence in Baltimore: No. 1725 N. Washington St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

Married

MARRIED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH.

Feb 201866

(Month)

(Day)

(Year)

7-AGE.

49 yrs. 4 mos. 2 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

ConductorB. & O. RR

9-BIRTHPLACE,

(State or Country),

Ind

10-NAME OF FATHER,

Henry Bitterbusch

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Mary Anholdt

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caroline G. Bitterbusch(Address) 1725 N. Washington

15-

Filed JUN 25 1915

ROBERT

KRAUT

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June231915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 17 1915, to June 23 1915, that I saw him alive on June 23 1915, and that death occurred, on the date stated above, at 2309 m.

The CAUSE OF DEATH* was as follows:

erysipelas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Septicemia

(Duration) yrs. mos. ds.

(Signed) Jacob Fisher M. D.June 24, 1915 (Address) 1926 E. 2nd ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Baltimore CountyJune 25 1915

20-UNDERTAKER

ADDRESS

Standa Dora1710 Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86253

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *319 Princeton Place* ST.; *12* WARD)FULL NAME *Pauline Green*(Residence in Baltimore: No. *319 Princeton Place* St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. *Female*4-COLOR OR RACE. *Col*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

11 *1*, *1913*
(Month) (Day) (Year)

7-AGE.

1 yrs., *7* mos., *24* ds.
If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country).*Maryland*

10-NAME OF FATHER.

*Joseph Green*11-BIRTHPLACE OF FATHER
(State or Country).*Maryland*

12-MAIDEN NAME OF MOTHER

*Emma Jones*13-BIRTHPLACE OF MOTHER
(State or Country).*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph Green*(Address) *319 Princeton Place*

15-

JUN 25 1915

ROBERT . KRAUTER,

Filed

191

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 24, *1915*
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *May 30* 1915, to *June 24* 1915,that I saw her alive on *June 24* 1915,and that death occurred, on the date stated above, at *40* m.

The CAUSE OF DEATH was as follows:

Cerebral Pneumonia(Duration) yrs. *1* mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. *1* mos. ds.(Signed) *R. C. ...**June 21*, 1915 (Address) *424 - East 23 St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Laurel Cemetery

DATE OF BURIAL.

June 26, 1915

20-UNDERTAKER

Geo. H. Holland

ADDRESS OF

Robert St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 S Collington Ave ST. 19 S Collington Ave WARD)

2-FULL NAME

(Residence in Baltimore: No. 19 S Collington Ave St. 19 S Collington Ave yrs. 19 mos. 19 da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH

Nov 23, 1844
(Month) (Day) (Year)

7-AGE

70 yrs. 7 mos. 18 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Bookkeeper9-BIRTHPLACE.
(State or Country),Baltimore Md

10-NAME OF FATHER

Joseph Holt11-BIRTHPLACE OF FATHER
(State or Country)Baltimore Md

12-MAIDEN NAME OF MOTHER

Sarah C Holton13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Holt(Address) 19 S Collington Ave

JUN 25 1915

Filed

ROBERT KRAUTER

SPECIAL PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 23rd 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from May 4 1915, to June 23 1915, that I saw him alive on June 22 1915, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Endarteritis and
thrombosis
(Duration) 1 yrs. 18 mos. 18 ds.CONTRIBUTORY
(Secondary)Obstruction
(Duration) 1 yrs. 18 mos. 18 ds.(Signed) Adolph C. Lindenberg, M. D.June 24, 1915 (Address) 7201-3 Collington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 19 yrs. 7 mos. 18 ds. In the State 19 yrs. 7 mos. 18 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery June 25 1915

20-UNDERTAKER

John A Moran & Son Bank

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86255

CERTIFICATE OF DEATH.

152

C86255

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 N. Greenmount Av. 10 ST. 10 WARD)

FULL NAME

Baby Noonan

(Residence in Baltimore: No.

825 Greenmount Av.

St.:

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 10.)

yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH.

June 21, 1915
(Month) (Day) (Year)

7-AGE.

3 mos. 3 ds.

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.

(State or Country),

Balto.

10-NAME OF FATHER,

Noonan, William

11-BIRTHPLACE OF FATHER

(State or Country),

Balto.

12-MAIDEN NAME OF MOTHER

Hawkins

13-BIRTHPLACE OF MOTHER

(State or Country),

Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

W. M. Frecke MD.

(Address).....

Johns Hopkins Hospital

15-

JUN 25 1915

ROBERT

JOHNS HOPKINS HOSPITAL

KRAUTER

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

JUN 25 1915

20-UNDERTAKER

ADDRESS

FOR ANATOMICAL PURPOSES

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86256

CERTIFICATE OF DEATH.

28

C86256

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Milliman St. ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith G. Handy(Residence in Baltimore: No. 1613 Milliman St. St.; 7 yrs. 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored5-SINGLE, MARRIED, Married,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

November 2, 1876
(Month) (Day) (Year)

7-AGE,

38 yrs. 0 mos. 0 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),Maryland

10-NAME OF FATHER,

John. Somerville

11-BIRTHPLACE OF FATHER,

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Mary. H. Collins

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary. H. Collins(Address) 1613 Milliman St.

JUN 25 1915

Filed..... 191

ROBERT . KRAUTER

Corial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 14 1915, to June 23 1915,that I saw her alive on June 19 1915,and that death occurred, on the date stated above, at 4 45 pm.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration)..... yrs. 6 mos. 0 ds.CONTRIBUTORY Exhaustion
(Secondary)(Duration)..... yrs. 0 mos. 0 ds.(Signed) Walter H. White M. D.June 25, 1915. (Address) 1101 B way

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. 0 mos. 0 ds. In the State..... yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel Cemetery June 27, 1915

20-UNDERTAKER

ADDRESS

Milton Davis 1608 Mc. Elderly St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86257

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hoap for Women* ST. *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Manchester Md* St. *14* yrs. *1* mos. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

6-DATE OF BIRTH,

June 25, 1915
(Month) (Day) (Year)

7-AGE,

yrs. *1* mos. *15* ds.If LESS than 1 day,
...hrs. or 15 min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Balto Md.*

10-NAME OF FATHER,

*Wm Reuben Shaffer Denner*11-BIRTHPLACE OF FATHER
(State or Country),*Manchester Md.*

12-MAIDEN NAME OF MOTHER

*Caroline Catherine Janzgiek*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Caroline Denner*(Address) *Manchester Md.*

15-

Filed

JUN 25 1915

Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

191 *5*, to *June 25* 191 *5*,
that I saw him alive on *June 25* 191 *5*,
and that death occurred, on the date stated above, at *8:15* a.m.

The CAUSE OF DEATH* was as follows:

Still-Birth (Breech Presentation)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *A. P. Jones* M. D.*June 25, 1915* (Address) *Womans Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *15* ds. State *14* yrs. *1* mos. *15* ds.Where was disease contracted, if not at place of death? *Manchester Md*Former or usual residence *Manchester Md*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Mt Carmel**June 25, 1915*

20-UNDERTAKER

ADDRESS

H. Sander & Sons 1700 E. St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1528 Baker street, St. 15 WARD)

REGISTERED No. C

2-FULL NAME Mamie Albaugh,

(Residence in Baltimore: No. 1608 N. Gilmore street, St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE 53 yrs. ? mos. ? ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housekeeper, (b) General nature of industry, business, or establishment in which employed (or employer), retired 3 years.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS. 10-NAME OF FATHER, Ephraim Albaugh, 11-BIRTHPLACE OF FATHER (State or Country), Maryland, 12-MAIDEN NAME OF MOTHER, Virginia Gallagher, 13-BIRTHPLACE OF MOTHER (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Miss Gertrude Ryan, niece, (Address) 1805 Warwick avenue.

15- ROBERT KRAUTH, Registrar, JUN 25 1915, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 24th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of skull, Caused by an accidental fall from front steps of house. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) Frederick Hempel, M. D. (Coroner.) June 25, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, New Cathedral, June 25, 1915

20-UNDERTAKER, ADDRESS, J. M. Gault, 1624 Mt. Royal Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2570 Wilkens Ave ST.; 20 WARD)FULL NAME Michael L. Bleicher(Residence in Baltimore: No. 2570 Wilkens Ave St.; 58 yrs., 7 mos., — ds.)REGISTERED No. C —

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Sept, 1886
(Month) (Day) (Year)

7-AGE,

31 yrs., 9 mos., — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Butcher

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER,

Louis Bleicher

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael L. Bleicher(Address) 2570 Wilkens Ave

15-

JUN 25 1915

ROBERT KRAUTH

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June, 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 12 1915, to June 24 1915,that I saw him alive on June 24 1915,and that death occurred, on the date stated above, at 1:20 p.m.

The CAUSE OF DEATH* was as follows:

Severe hemorrhage of brain(Duration) 6 yrs., — mos., — ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs., — mos., — ds.(Signed) J. T. O'Brien M. D.June 24, 1915 (Address) 1042 Eden aue

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

New BaltimoreJune 25, 1915

20-UNDERTAKER

ADDRESS

Dr. J. T. O'Brien624 W. Royal Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 N. Carey ST.: 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1712 N. Carey St.: 46 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, Oct 20, 1868
(Month) (Day) (Year)7-AGE, 46 yrs.,.....mos.....ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, City Forester
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Baltimore Md10-NAME OF FATHER, Michael Wade11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md12-MAIDEN NAME OF MOTHER, Eileen Watson13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. James Wade(Address) 1712 N. Carey St.15-JUN 25 1915 Filed.....191.....

ROBERT J. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6 24, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1914, to June 24 1915, that I saw h. Man alive on June 23 1915, and that death occurred, on the date stated above, at 5 P. m.The CAUSE OF DEATH* was as follows:
myocardial..... (Duration).....yrs. 8 mos. 14 ds.
CONTRIBUTORY.....Quint Temo
(Secondary)..... (Duration).....yrs.....mos.....ds.
(Signed) Eduard DeWolfe M. D.
June 25, 1915. (Address) 208 Anyuill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New CathedralDATE OF BURIAL, June 25, 191520-UNDERTAKER, Wm. M. GauthierADDRESS, 1624 m. Ray

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86262

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86262

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. 25 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

July 28th, 1866.
(Month) (Day) (Year)

7-AGE,

48 yrs. 10 mos. 27 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Physician

9-BIRTHPLACE, (State or Country),

Columbia N.C.

PARENTS.

10-NAME OF FATHER,

Wm L. Spruill

11-BIRTHPLACE OF FATHER (State or Country),

North Carolina

12-MAIDEN NAME OF MOTHER

Martha Walker

13-BIRTHPLACE OF MOTHER (State or Country),

North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Charles W. Mitchell

(Address).....

9 E Chase St

15-

JUN 26 1915

HARRY O. ANDREWS,

Filed JUN 26 1915 Serial Permt. Officer's Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 15th, 1915, to June 24th, 1915,

that I saw him alive on June 24th, 1915,

and that death occurred, on the date stated above, at 2:10 p. m.

The CAUSE OF DEATH* was as follows:

Influenza - Septic bronchitis -
General sepsis

(Duration)..... yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

Pulmonary edema

(Duration)..... yrs. mos. 1 ds.

(Signed)..... M. D.

June 25th, 1915. (Address)..... 9 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cem

June 26, 1915

20-UNDERTAKER

ADDRESS

Henry W. Jenkins Sons to the Catholic Church

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *St. Vincent's Inf. Asy.* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Inf. Asylum* St. *14* yrs. *2* mos. *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 13th, 1915
(Month) (Day) (Year)

7-AGE,

2 yrs. 2 mos. 11 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1701 Division St.*

15-

Filed *JUN 26 1915* HARRY O. ANDREWS,
Regist. *101* *Burial Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 1st 1915* to *June 24 1915*, that I saw her alive on *June 23 1915*, and that death occurred, on the date stated above, at *2.30 p.m.* The CAUSE OF DEATH* was as follows:*Malnutrition & Mal-assimilation*(Duration) *2 yrs. 2 mos. 11 ds.*CONTRIBUTORY
(Secondary)(Duration) *2 yrs. 2 mos. 11 ds.*(Signed) *Elmer G. Hall* M. D.*June 24, 1915* (Address) *1617 E. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. *11* ds. In the State yrs. *2* mos. *11* ds.Where was disease contracted, if not at place of death? *St. Vincent's Inf. Asylum*Former or usual residence *St. Vincent's Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Ave *June 26 1915*

20-UNDERTAKER

ADDRESS

Martin Lakey, 606 Lafayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Notre Dame Asquith St. 10* REGISTERED NO. C
 CITY OF BALTIMORE; (NO. *10* ST. *10* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)
 2-FULL NAME *Sister Mary Marie Sale*
 (Residence in Baltimore: No. *Notre Dame Asquith St.* St. *4* yrs. *5* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *Oct 11, 1867*
 (Month) (Day) (Year)

7-AGE, *47 yrs. 5 mos. 13 ds.* IF LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Teacher*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *London England*

10-NAME OF FATHER, *Robert Sale*
 11-BIRTHPLACE OF FATHER (State or Country), *England*
 12-MAIDEN NAME OF MOTHER *Isabelle Fellme*
 13-BIRTHPLACE OF MOTHER (State or Country), *England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sister Mary Claire*

(Address) *Notre Dame Asquith St.*

15- *JUN 26 1915* HARRY O. ANDREWS, Registrar.

16- *JUN 26 1915* HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 24, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 1915* to *June 14, 1915*, that I saw him alive on *June 27, 1915*, and that death occurred, on the date stated above, at *2 P. m.*

The CAUSE OF DEATH* was as follows:

Spontaneous left breast
inoperable (Duration) *12 yrs. 5 mos. 13 ds.*

CONTRIBUTORY (Secondary)

(Duration) *12 yrs. 5 mos. 13 ds.*

(Signed) *J. J. Kelly* M. D.

June 25, 1915 (Address) *110 E. Pratt St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *4 yrs. 5 mos. 13 ds.* In the *4* yrs. *5* mos. *13* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Notre Dame Asquith St.*

19-PLACE OF BURIAL OR REMOVAL, *Notch Cliff Abol.* DATE OF BURIAL, *June 26, 1915*

20-UNDERTAKER *G. Kirk & Son* ADDRESS *915 N. Gay St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86265

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86265

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Belvedere Hotel* ST. *4* WARD)

FULL NAME *Frederick Herman Guertler*

(Residence in Baltimore: No. *226 N. Liberty St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

1 (Month) *1* (Day) (Year)

7-AGE

about 47 yrs. mos. ds.

If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Bar-tender

9-BIRTHPLACE,
(State or Country),

Dresden Germany

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Mear*

(Address) *805 N. Calvert St.*

15-

JUN 26 1915

Filed....., 191.. *Burial Permit Clerk*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) And that said deceased came to *this* death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute cardiac dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis

(Duration) yrs. mos. ds.

(Signed) *W. H. Frank* M. D.
(Coroner.)

June 24, 1915 (Address) *18 W. Frank St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

National Cemetery

DATE OF BURIAL,

6/26, 1915

20-UNDERTAKER

Henry W. Mear & Son

ADDRESS

805 N. Calvert St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 W Saratoga ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1036 W Saratoga St.; 10 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-STATUS.

Married

(Write the word.)

6-DATE OF BIRTH

Not Known 1858
(Month) (Day) (Year)

7-AGE,

57 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

Retired Soldier9-BIRTHPLACE,
(State or Country),Portland Maine

10-NAME OF FATHER,

Leary.11-BIRTHPLACE OF FATHER
(State or Country),Not Known

12-MAIDEN NAME OF MOTHER

Not Known13-BIRTHPLACE OF MOTHER
(State or Country),Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Catherine L Leary(Address) 1036 W Saratoga St

15-

JUN 26 1915 191. Serial 121. Permit. Alat. 5

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 23rd, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1913, to June 23rd 1915, that I saw him alive on June 23rd 1915, and that death occurred, on the date stated above, at 10.15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis(Duration) 7 yrs. 5 mos. 5 ds.CONTRIBUTORY
(Secondary)Coronary Artery Disease
(Duration) 3 yrs. 3 mos. 5 ds.(Signed) John H. Williams M. D.
June 25th 1915. (Address) 530 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park.

DATE OF BURIAL,

June 26 1915

20-UNDERTAKER

Geo A Gerbig

ADDRESS

Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 S. Washington ST., 2 WARD)

2-FULL NAME

(Residence in Baltimore: No. 412 S. Washington St.; — yrs., — mos — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

June 9, 1915
(Month) (Day) (Year)

7-AGE,

16 yrs., 16 mos., 16 ds.If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none
Infant9-BIRTHPLACE,
(State or Country).Baltimore County Md

10-NAME OF FATHER,

Julian Oleksiewicz11-BIRTHPLACE OF FATHER
(State or Country).Russia Poland

12-MAIDEN NAME OF MOTHER

Jucyna Kluga13-BIRTHPLACE OF MOTHER
(State or Country).Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Julian Oleksiewicz

(Address)

412 S. Washington St.

15-

JUN 26 1915

HARRY O. ANDREWS,

Filed

191. Serial Permit 01014

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 25, 1915, to June 25, 1915, that I saw h e alive on June 25, 1915, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Infection

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Cardiac Debility

(Duration) yrs. mos. ds.

(Signed) H. S. Swalski M. D.June 25, 1915. (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary, June 26, 1915

20-UNDERTAKER

ADDRESS

William Hallman, 1618 Eastern Ave.WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86268

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86268

CERTIFICATE OF DEATH

(PLACE OF DEATH)

CITY OF BALTIMORE (No. *11, E. Montgomery*)

FULL NAME *Catherine P. Tyler*

(Residence in Baltimore: No. *11, E. Montgomery*)

ST.: *22*

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., *59* mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) *Married*

6-DATE OF BIRTH

Aug

12, *1885*

7-AGE,

59 yrs., *10* mos., *13* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country)

Baltimore Md

10-NAME OF FATHER

Abel Waddey

11-BIRTHPLACE OF FATHER (State or Country)

Va.

12-MAIDEN NAME OF MOTHER

Margaret Edwards

13-BIRTHPLACE OF MOTHER (State or Country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William T. Tyler*

(Address) *11, E. Montgomery*

15

JUN 26 1915

ROBERT KRAUTER,

Filed

191

Burial Permit

Registrar.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

And that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH was as follows:

Public Chronic

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

(Coroner.)

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

LOUDON PARK

DATE OF BURIAL

JUN 26 1915

20-UNDERTAKER

ARMSTRONG-DENNY CO.

ADDRESS

715 Light St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *Mersey Hospital* ST. *22* WARD)
FULL NAME *Edward Ranson*
(Residence in Baltimore: No. *506 S. Charles St.* St.; yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH, *unknown*, 1 (Month) (Day) (Year)
7-AGE, *20* yrs. mos. ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *sterilizer*
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), *Richmond, Va.*
10-NAME OF FATHER, *James Ranson*
11-BIRTHPLACE OF FATHER (State or Country), *Va.*
12-MAIDEN NAME OF MOTHER *Unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Myria Christian*
(Address) *506 S. Charles St.*

15- *JUN 26 1915* *ROBERT KRAUTER*
Filed *1915* *Marital Permit Clerk*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 22, 1915*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest, autopsy or inquiry* thereon and from the evidence obtained by said *inquest, autopsy or inquiry* and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Gunwound - Perforated wound of abdomen
(Duration) *1 hour* yrs. mos. ds.
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) *Thos. Chambers* M. D.
(Coroner.)
June 23 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death *1 hour* In the yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, *St. Andrew* DATE OF BURIAL, *June 27 1915*
20-UNDERTAKER *Wilbert Brown* ADDRESS *306 N. Mount St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86270

CERTIFICATE OF DEATH.

80

C86270

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 N. Eden ST. 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1120 N. Eden St. 50 yrs., mos., ds.)George W. Murphy

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

February 7th, 1879
(Month) (Day) (Year)

7-AGE.

66 yrs., 4 mos., 17 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Foreman
Md Steel Co9-BIRTHPLACE,
(State or Country),Louisville Ky

10-NAME OF FATHER.

Ephraim Murphy11-BIRTHPLACE OF FATHER
(State or Country),U. S.

12-MAIDEN NAME OF MOTHER

Mary B. Brown13-BIRTHPLACE OF MOTHER
(State or Country),Harford Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ella F Murphy(Address) 1120 N. Eden St

15-

JUN 26 1915ROBERT KRAUTERSerial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 16, 1915, to June 24, 1915,that I saw him alive on June 24, 1915,and that death occurred, on the date stated above, at 7:15 P. M.

The CAUSE OF DEATH* was as follows:

Clonus pectoris(Duration) 2 yrs., mos., ds.CONTRIBUTORS
(Secondary)(Duration) 2 1/2 yrs., mos., ds.(Signed) Dr. A. Hartman M. D.June 25, 1915 (Address) 1121 N. Camden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park CemeteryJune 27, 1915

20-UNDERTAKER

ADDRESS

George Schilling & Sons 1126 E MonumentWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

825 N Bond

ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Edward H Scheler

(Residence in Baltimore: No.

525 N. Bond

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

March 28th, 1912

(Month)

(Day)

(Year)

7-AGE,

3 yrs. 2 mos. 26 ds.

If LESS than 1 day

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

Baltimore Md

10-NAME OF FATHER,

J. B. W. Scheler

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Anna E. Bell

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

John S. W. Scheler

(Address).....

525 N. Bond St

15-

JUN 26 1915

ROBERT KRAUTER,

Bureau Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from June 19 1915, to June 25 1915, that I saw him live on June 23, 1915, and that death occurred, on the date stated above, at 3:55 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis tubercular

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Tuberculosis

(Signed).....

June 24, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

June 26, 1915

ADDRESS

1126 E Monument

20-UNDERTAKER

Georgi Schelling & Sons

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *726, Cumberland* ST.; *15* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2—FULL NAME *Robert S. Bradley*(Residence in Baltimore: No. *726 Cumberland* St.; *69* yrs., *11* mos., *28* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3—SEX, *Male*4—COLOR OR RACE, *White*5—SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*6—DATE OF BIRTH, *June 28, 1845*7—AGE, *69* yrs., *11* mos., *28* ds.

If LESS than 1 day, ... hrs. or ... min.?

8—OCCUPATION:

(a) Trade, profession, or particular kind of work, *Printer*

(b) General nature of industry, business, or establishment in which employed (or employer)

9—BIRTHPLACE, (State or Country), *Maryland*

PARENTS.

10—NAME OF FATHER, *James Bradley*11—BIRTHPLACE OF FATHER (State or Country), *England*12—MAIDEN NAME OF MOTHER, *Kennetha Whitlock*13—BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14—THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Egon Bradley Ebaugh*(Address) *700 W. North Ave.*

15—

JUN 26 1915 *ROBERT S. KRAUTER*
Regist. *Permit*

MEDICAL CERTIFICATE OF DEATH.

16—DATE OF DEATH, *June 25, 1915*17 I HEREBY CERTIFY, That I attended deceased from *June 3, 1915* to *June 25, 1915*, that I saw him alive on *June 25, 1915*, and that death occurred, on the date stated above, at *1:20 P.* m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Neoplasm

CONTRIBUTORY (Secondary)

(Signed) *James Ebaugh* M. D.
June 25, 1915 (Address) *714 W. N. Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18—LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19—PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL, *June 27, 1915*20—UNDERTAKER, *W. W. Raiton*ADDRESS *230 N. Ave.*WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

086273

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

43 086273

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2428 Greenmount Ave 12 WARD)

2-FULL NAME Mrs Sarah E. Rudolph

(If death occurred in a hospital or institution, give its NAME instead of street and number and Rm out No. 18.)

(Residence in Baltimore: No. 2428 Greenmount Ave St; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Aug 10 1870

(Month) (Day) (Year)

7-AGE

44 yrs. 10 mos. 14 ds.

If LESS than 1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE

(State or country)

Baltimore Co

10-NAME OF FATHER

Thos B. Christopher

11-BIRTHPLACE OF FATHER

(State or country)

Baltimore County

12-MAIDEN NAME OF MOTHER

Sarah E. Youngman

13-BIRTHPLACE OF MOTHER

(State or country)

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas G Rudolph

(Address)

2428 Greenmount Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 23 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1915, to, June 23, 1915,

that I saw her alive on June 23, 1915,

and that death occurred, on the date stated above, at 4:50 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast
(Operation + Microscopic Examination)

(Duration)

yrs

mos

ds

Contributory (SECONDARY)

(Duration)

yrs

mos

ds

(Signed)

John H. Henshaw M. D.

June 24, 1915

[Address]

3100 Fairview

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs

mos

ds

In the State

yrs

mos

ds

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Lawn

June 27, 1915

20-UNDERTAKER

ADDRESS

William Cook

502 C. North Ave

JUN 26 1915

Filed 1915

ROBERT KRAUTER,

Morial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1609 St. Paul* ST. *12* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1609 St. Paul* St. *14* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH

December 26, 18*34*
(Month) (Day) (Year)

7-AGE

80 yrs. *5* mos. *28* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), *Crossadore Talbot Co. Md.*

10-NAME OF FATHER

Samuel Dickerson

11-BIRTHPLACE OF FATHER

(State or Country), *Talbot Co. Md.*

12-MAIDEN NAME OF MOTHER

Maria Goldborough

13-BIRTHPLACE OF MOTHER

(State or Country), *Carroll Co. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Madie S. Buehler*(Address), *1609 St. Paul St.*

15-

JUN 26 1915

ROBERT

KRAUTER

Filed..... 191

Suppl. Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Jan 24, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 23 191*4*, to *Jan 24* 191*5*,
that I saw h *er* alive on *Jan 24* 191*5*,and that death occurred, on the date stated above, at *10:15* p.m.

The CAUSE OF DEATH* was as follows:

Cholecystitis and cholelithiasis(Duration) *1* yrs. *5* mos. ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. *5* mos. ds.(Signed) *Frank D. Ryan* M. D.*Jan 24*, 191*5*. (Address) *1619 St. Paul St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

CROSSADORE CEMETERY
CROSSADORE TALBOT CO MD.

DATE OF BURIAL

June 26, 1915.

20-UNDERTAKER

Henry H. Jenkins & Sons Co *Richard St.*WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Home + 2nd*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Annapolis Md.*)

St.; yrs. mos. 1 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH,

June 16, 1873
(Month) (Day) (Year)

7-AGE,

42 yrs. — *10* mos. — *10* da.
It LESS than 1 day.
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Seamstress*
(b) General nature of industry, business, or establishment in which employed (or employer). *Shoe*9-BIRTHPLACE,
(State or Country),*Baltimore Md.*

PARENTS.

10-NAME OF FATHER,

*Joseph Knighton*11-BIRTHPLACE OF FATHER
(State or Country),*Annapolis Md.*

12-MAIDEN NAME OF MOTHER

*Ella Brashears*13-BIRTHPLACE OF MOTHER
(State or Country),*Anne Arundel Co Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ella Knighton*(Address) *No 1 Dean St. Annapolis Md.*

15-

*JUN 26 1915**ROBERT KRAUTH**Capital Police Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 26, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *June 25 1915* to *June 26 1915*, that I saw her alive on *June 26 1915*, and that death occurred, on the date stated above, at *2:10 A.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) ... yrs. ... mos. ... da.CONTRIBUTORY
(Secondary)(Signed) *J. Davis Reichard* M. D.
June 26 1915 (Address) *Church Home + 2nd*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* da. *42* yrs. *4* mos. *10* da.Where was disease contracted, if not at place of death? *Baltimore*Former or usual residence *Annapolis, Md*

19-PLACE OF BURIAL OR REMOVAL,

Annapolis Md.

DATE OF BURIAL,

June 26 1915

20-UNDERTAKER

H. E. Hyde

ADDRESS

17 Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4428 E. Madison* ST. *10* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1428 E. Madison* St.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs., mos. da)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Col*5-SINGLE, MARRIED, *married*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Feb 19, 1884
(Month) (Day) (Year)

7-AGE,

31 yrs. 4 mos. 5 ds. IF LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....*Housework*
(b) General nature of industry, business, or establishment in which employed (or employer).....*Washing*

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Jm Johnson

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Rosa Brown

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*Rosa Johnson*(Address).....*4428 E. Madison*

15-

JUN 26 1915 ROBERT KRAUTER,
FIR... Serial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 20* 1915, to *June 24* 1915, that I saw her alive on *June 23* 1915, and that death occurred, on the date stated above, at *6:10 a.m.*

The CAUSE OF DEATH* was as follows:

Coronary Artery with Atherosclerosis(Duration).....yrs. *5* mos. *8* ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.mos.ds.

(Signed).....*W. C. Burns*.....M. D.*June 24* 1915 (Address).....*2218 E Pratt*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Lamel C

DATE OF BURIAL,

June 27, 1915

20-UNDERTAKER

Robt A Elliott 506 East St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1221 St. Matthew* ST.; *5* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1221 St. Matthew St.* St.; yrs. mos. da.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *married*

6-DATE OF BIRTH,

October 18, 1860

(Month) (Day) (Year)

7-AGE,

54 yrs. 4 mos. 6 da.

IF LESS than 1 day.

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Journalist*(b) General nature of industry, business, or establishment in which employed (or employer). *Employer, Const. Hony*

9-BIRTHPLACE, (State or Country),

Penna

PARENTS.

10-NAME OF FATHER,

John Battista Arratia

11-BIRTHPLACE OF FATHER (State or Country),

Genoa Italy

12-MAIDEN NAME OF MOTHER

Angelina

13-BIRTHPLACE OF MOTHER (State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anna Arratia*(Address) *1221 St. Matthew*

15-

JUN 26 1915

ROBERT . KRAUSE,

19 *Official Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan 17, 1915, to June 24, 1915,*that I saw him alive on *June 24, 1915,*and that death occurred, on the date stated above, at *3 P* m.

The CAUSE OF DEATH* was as follows:

Diphtheria mellitus

CONTRIBUTORY. (Secondary)

(Duration) *1* yrs. *1* mos. *1* da.(Signed) *Edward J. Leach* M. D.*6124, 1915* (Address) *413 N. Washington*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Balto Cemetery

DATE OF BURIAL,

June 25, 1915

20-UNDERTAKER

J. Ahrens & Co

ADDRESS

1611 Madison

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 Lancaster ST.; V WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1807 Lancaster St.; yr. mon. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word)Single

6-DATE OF BIRTH,

January 1, 1912
(Month) (Day) (Year)

7-AGE,

3 yrs. 5 mos. 24 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Child9-BIRTHPLACE,
(State or Country),Russia Poland,

10-NAME OF FATHER,

John Rogalski11-BIRTHPLACE OF FATHER
(State or Country)Russia Poland

12-MAIDEN NAME OF MOTHER

Hanislawa Szopozak13-BIRTHPLACE OF MOTHER
(State or Country),Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUN 26 1915

ROBERT

KRAUTER

Marital Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 24 1915, to June 25 1915, that I saw him alive on June 25 1915, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis(Duration)....yrs....mos....4 ds.CONTRIBUTORY
(Secondary)(Duration)....yrs....mos....1 ds.

(Signed)

J. M. Delerco M. D.
June 25, 1915 (Address) 621 Columbia Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Holy RosaryJune 26 1915

20-UNDERTAKER

ADDRESS

M. J. Sadowski175 S. Union

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86279

CERTIFICATE OF DEATH.

PLACE OF DEATH Union Protestant Infirmary,
Y OF BALTIMORE (No. 1514-30 Division street, ST. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Edward Grant.

(Residence in Baltimore: No. 2822 Walbrook avenue.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, Single, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, May 21st, 1904.
(Month) (Day) (Year)

7-AGE, If LESS than 1 day,
 11 yrs. 1 mos. 4 ds. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At school.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),
Baltimore. Md.

10-NAME OF FATHER, William B. Grant.

11-BIRTHPLACE
OF FATHER
(State or Country), Baltimore, Md.

12-MAIDEN NAME
OF MOTHER Mary Seufert.

13-BIRTHPLACE
OF MOTHER
(State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William B. Grant, father.

(Address) .. 2822 Walbrook avenue

15- ROBERT . KRKOVIC

JUN 26 1915. Serial Permit Office

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 25th, 1951.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the
remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-
..... Inquest..... And that said deceased came to his death
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

... Concussion of the brain and prob-
... able fracture of the skull caused
... by being struck accidentally by an
... automobile, (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY.....
(Secondary) *172*.....
..... (Duration) *172*.....

(Signed) Richard C. Campbell M. D.
(Coroner.)

June 25 1915. (Address) 3310 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL

...the disk ...

TU-UNDERTAKER	ADDRESS
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Wm. H. Brown

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86280

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86280

1-PLACE OF DEATH

150
REGISTERED No. C

CITY OF BALTIMORE (No.

2820 Harlem ave.

16 WARD)

2-FULL NAME

James J. Manley

(Residence in Baltimore: No.

2820 Harlem Ave.

St.: yrs. 1 mos. 2 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

May

23, 1915

7-AGE

1 yrs. 2 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or country)

Maryland

10-NAME OF FATHER

William E. Manley

11-BIRTHPLACE OF FATHER

(State or country)

Md.

12-MAIDEN NAME OF MOTHER

Lora R. Bell

13-BIRTHPLACE OF MOTHER

(State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Margaret Bell

(Address)

1314 Edmondson

15-

JUN 26 1915

ROBERT . KRAUTH,

Mutual Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

25

1915

17. I HEREBY CERTIFY. That I attended deceased from May 23, 1915, to June 25, 1915.

that I saw him alive on June 11, 1915,

and that death occurred, on the date stated above, at 6:45 P.m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

Contributory (SECONDARY)

(Signed) J. Wesley Cole, M. D.

June 26, 1915 (Address) 2202 Barnard Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 1 mos. 2 ds. In the State yrs. 1 mos. 2 ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

2820 Harlem ave

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

June 27, 1915

20-UNDERTAKER

John H. Bell

ADDRESS

2820 Harlem Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (NO. *Locust Point Bro. Pier* ST. *21* WARD)

2-FULL NAME

(Residence in Baltimore: No. *508 W. West*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Not known*

6-DATE OF BIRTH, *Not known*, 1881 (Month) (Day) (Year)

7-AGE, *34* yrs. — mos. — ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Longshoreman* (b) General nature of industry, business, or establishment in which employed (or employer). *Stevedore*

9-BIRTHPLACE, (State or Country), *Ind*

10-NAME OF FATHER, *Sam Jackson*

11-BIRTHPLACE OF FATHER (State or Country), *Ind*

12-MAIDEN NAME OF MOTHER, *Martha Freeman*

13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joe Mc Daniels*

(Address) *536 Lee St.*

15- *ROBERT E. BRADY*

Filed *JUN 26 1915* 191. *Marial Permit Clerk*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 24*, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry* (Inquest, au-

topsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary)

(Duration)yrs.mos.ds.

(Signed) *W. Jones* M. D. (Coroner.)

June 26, 1915 (Address) *316 O'Connell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Caring to Calvert Co. Md*

DATE OF BURIAL, *June 28 1915*

ADDRESS

20-UNDERTAKER *Alfred J. Freedland* 114 N. ...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Base Wharf*)

FULL NAME *G. Martin Lichikson*

(Residence in Baltimore, No. *Bergen, Norway*)

ST. *3*

WARD

REGISTERED No. C. *169*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male.

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Not known

6-DATE OF BIRTH,

Not known, 188*8*
(Month) (Day) (Year)

7-AGE,

26 yrs. — mos. — da.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Fireman

(b) General nature of industry, business, or establishment in which employed (or employer).

J. S. Haus Broga

9-BIRTHPLACE,

(State or Country),

Norway

PARENTS.

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER (State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *R. H. Christensen*

(Address) *12th Office J. S. Haus Broga*

15-

Filed

JUN 26 1915

ROBERT K. KNOTT

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24, 191*5*
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry*
(Inquest, au-

inquiry and that said deceased came to *his* death
topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... da.

(Signed) *David W. Jones* M. D.
(Coroner.)

June 26 191*5* (Address) *3116 Woodward St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death ... yrs. ... mos. ... da. State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Evangelical Church June 27, 1915

20-UNDERTAKER

ADDRESS

J. Sander Son 1710 Fleet St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1143* *Humbert* ST.; *24* WARD)2-FULL NAME *Franz Zeman*(Residence in Baltimore: No. *1143* *Humbert* St.; yrs. mos. *16* *hrs.*)151
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

6 - 25 - 1915
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,

yrs. mos. ds.

16 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

none

9-BIRTHPLACE,

(State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Franz Zeman

11-BIRTHPLACE OF FATHER

(State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Louisa Schmidt

13-BIRTHPLACE OF MOTHER

(State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

St. Proch.

(Address).....

1570 7th.

15-

JUN 27 1915

Filed.....

*ROBERT . KRAUTER**Maria Perait Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

6 - 26 - 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

6 - 25 1915, to *6 - 26 1915*,that I saw him live on *6 - 26 1915*,and that death occurred, on the date stated above, at *2 P.m.*

The CAUSE OF DEATH* was as follows:

Premature birth (6 mos.)

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... *St. Proch.* M. D.*6-26, 1915* (Address)..... *1570 7th. City*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Proch. & Co. June 27, 1915

20-UNDERTAKER

ADDRESS

St. Proch. & Co. 1318 1st St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

150

C86285

1-PLACE OF DEATH

CITY BALTIMORE: (No. *404 Grindall St.* St. *24* WARD)

2-FULL NAME

(Residence in Baltimore: No. *404 Grindall St.* St. _____ yrs. _____ mos. _____ ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *June 14, 1915*
(Month) (Day) (Year)

7-AGE _____ If LESS than 1 day, _____ hrs., _____ yrs. _____ mos. _____ ds. or min.?

8-OCCUPATION *None*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Balto Md.*

PARENTS
10-NAME OF FATHER *J. C. Smith*
11-BIRTHPLACE OF FATHER (State or country) *Balto Md.*
12-MAIDEN NAME OF MOTHER *Hester, Mary*
13-BIRTHPLACE OF MOTHER (State or country) *Balto Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Winnie Smith*
(Address) *404 Grindall St.*

15-*JUN 27 1915* *ROBERT KRAUTER*
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 26, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 15, 1915*, to *June 26, 1915*, that I saw him alive on *June 25, 1915*, and that death occurred, on the date stated above, at *8 a.* m.
The CAUSE OF DEATH* was as follows:

Defective Circulation
Blue Body
(Duration) _____ yrs. _____ mos. *13* ds.

Contributory (SECONDARY) *None*
(Signed) *J. E. Edwards* M. D.
June 26, 1915 [Address] *910 E. Pratt St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____
Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL *Johns Creek* DATE OF BURIAL *June 27, 1915*

20-UNDERTAKER *Wm. Baker & Sons* ADDRESS *315 Light St.*

WRITE PLAINLY, WITH UNFADING INK THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86286

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86286

CERTIFICATE OF DEATH

1-PLACE OF DEATH

50

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *1419 Eager* ST. *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Minna M. Lehner*

(Residence in Baltimore: No. *1419 Eager* St. *Life* yrs. *Life* mos. *Life* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*

4-COLOR OR RACE *White*

5-SINGLE *Widow*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Oct 28, 1850*

(Month)

(Day)

(Year)

7-AGE *64* yrs. *7* mos. *27* ds. or *1* day *7* hrs. *27* min.?

If LESS than

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Home

9-BIRTHPLACE (State or country)

Baltimore City

10-NAME OF FATHER *William Mullmeyer*

11-BIRTHPLACE OF FATHER (State or country)

Austria

12-MAIDEN NAME OF MOTHER *Anna Bronie*

13-BIRTHPLACE OF MOTHER (State or country)

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Frank C. Lehner*

(Address) *1419 Eager St.*

15-

JUN 27 1915

ROBERT A. RAUTER,

Health Officer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 25, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 24, 1915* to *June 25, 1915*

that I saw her alive on *June 25, 1915* and that death occurred, on the date stated above, at *3:45* p. m.

The CAUSE OF DEATH* was as follows:

Diabetes
acute
hyperglycemic
coma
with
acidosis

Contributory (SECONDARY)

(Duration) *5* yrs. *5* mos. *5* ds.

(Signed) *William J. Ryan, M.D.*

June 25, 1915 [Address] *2008 Ashland St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cemetery

June 28, 1915

20-UNDERTAKER

ADDRESS

Henry Brock Sun

1361 E. Eager St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86287

CERTIFICATE OF DEATH.

37

C86287

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *West End maternity* ST; *1915* WARD)

2-FULL NAME

(Residence in Baltimore: No. *7th Bruce* St; *6* yrs., *6* mos. *6* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Single*

6-DATE OF BIRTH,

June 21, 1915
(Month) (Day) (Year)

7-AGE,

6 mos. *6* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

*None*9-BIRTHPLACE,
(State or Country),*Baltimore city*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo. G. Swarr*(Address) *Franklin Square Has*

15-

JUN 27 1915 *ROBERT KRAUTER*
Filed *1915* *Robert Krauter*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 27, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 21, 1915*, to *June 26, 1915*,
that I saw him alive on *June 26, 1915*,
and that death occurred, on the date stated above, at *1 a.m.*

The CAUSE OF DEATH* was as follows:

Congenital syphilis(Duration) *6* yrs. *6* mos. *6* ds.CONTRIBUTORY
(Secondary)(Duration) *6* yrs. *6* mos. *6* ds.(Signed) *Geo. G. Swarr* M. D.*6/27, 1915* (Address) *Franklin Square Has*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *6* yrs. *6* mos. *6* ds. In the State *6* yrs. *6* mos. *6* ds.Where was disease contracted, if not at place of death? *Congenital*Former or usual residence *7 Bruce St.*

19-PLACE OF BURIAL OR REMOVAL.

Mo Zion Cem *June 27, 1915*

20-UNDERTAKER

a. Jones *207 S. Stricker St*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE		
CERTIFICATE OF DEATH.		
PLACE OF DEATH		
CITY OF BALTIMORE (No. <i>16 East</i> ST. <i>5</i> WARD) REGISTERED No. C. <i>79</i>		
FULL NAME <i>Isaiah Anderson</i>		
(Residence in Baltimore: No. <i>16 East A.</i> St.; yrs., mos. ds.)		
PERSONAL AND STATISTICAL PARTICULARS.		
3-SEX. <i>male</i>	4-COLOR OR RACE. <i>Black</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Single</i>
6-DATE OF BIRTH. <i>Unknown</i> , 1 (Month) (Day) (Year)		
7-AGE. <i>65</i> yrs. mos. ds. If LESS than 1 day, hrs. or min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>none</i> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE. (State or Country), <i>Maryland</i>		
PARENTS.	10-NAME OF FATHER, <i>Unknown</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Md.</i>	
	12-MAIDEN NAME OF MOTHER, <i>Unknown</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Unknown</i>	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Martha Lynd</i> (Address) <i>16 East A.</i>		
15- <i>JUN 27 1915</i> ROBERT . KRAUTER, <i>United States National Cemetery</i> Filed....., 191. <i>16</i> Burial Permit Clerk, Registrar.		
CORONER'S CERTIFICATE OF DEATH.		
16-DATE OF DEATH. <i>June 26</i> , 191 <i>5</i> (Month) (Day) (Year)		
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>inquiry</i> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <i>inquiry</i> (Inquest, autopsy or inquiry.) and that said deceased came to <i>her</i> death on the day stated above.		
The CAUSE OF DEATH* was as follows: <i>Valvular Heart Disease</i> <i>(Mitral insufficiency)</i> (Duration) <i>13</i> yrs. mos. ds.		
CONTRIBUTORY (Secondary) <i>None</i> (Duration) <i>13</i> yrs. mos. ds.		
(Signed) <i>Wm. M. Savage, M. D.</i> (Coroner.) <i>June 26</i> , 191 <i>5</i> (Address) <i>1729 Madison Ave.</i>		
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds. Where was disease contracted, if not at place of death?.....		
Former or usual residence.....		
19-PLACE OF BURIAL OR REMOVAL, <i>United States National Cemetery</i> DATE OF BURIAL, <i>June 28, 1915</i>		
20-UNDERTAKER, <i>Helix B. Page</i> ADDRESS, <i>102 E. Mulberry St.</i>		

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86289

CERTIFICATE OF DEATH

x171

C86289

1-PLACE OF DEATH *Med. General Hospital*
 CITY OF BALTIMORE: (No. *Cor. Madison & Linden Ave.*) WARD)
 2-FULL NAME *John Rosier*
 (Residence in Baltimore: No. *New Freedom Pa.* St.; yrs., mos., da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married* (Write the word.)
 6-DATE OF BIRTH, *June 21, 1876*
 (Month) (Day) (Year)
 7-AGE, *39* yrs. — *6* mos. — *6* da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work *Laborer*
 (b) General nature of industry, business, or establishment in which employed (or employer) *Farm Hand*

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Bigo Rosier*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER *Liza Tracey*

13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *H. H. Brown*
 (Address) *New Freedom Pa.*

15- *JUN 27 1915* *ROBERT . KRAUTER*
 Filed..... 191. *Marial Permit Officer*
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 27, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 24, 1915*, to *June 27, 1915*, that I saw him alive on *June 27, 1915*, and that death occurred, on the date stated above, at *2 a. m.*

The CAUSE OF DEATH* was as follows:

Septicemia - Accidental Wound
7 ft. knee caused by axe

(Duration) yrs. mos. *10* da.
 CONTRIBUTORY. *Ac. Cardiac Dilatation*
 (Secondary)

(Duration) yrs. mos. *1* da.
 (Signed) *Charles H. Hull* M. D.
June 27, 1915 (Address) *Med. Gen. Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *3* da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death? *New Freedom Pa.*

Former or usual residence *New Freedom Pa.*

19-PLACE OF BURIAL OR REMOVAL, *Removal to New Freedom Pa.* DATE OF BURIAL, *June 30, 1915.*

20-UNDERTAKER, *W. J. Thomas* ADDRESS *New Freedom Pa.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 N. Broadway

ST.; 7 WARD)

REGISTERED NO. C

2-FULL NAME Jane Murphy

(Residence in Baltimore: No. 705 N. Broadway

St.; 68 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and all out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
 4-COLOR OR RACE. White
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June 27th. 1831.
 (Month) (Day) (Year)

7-AGE, 84 yrs. --- mos. --- ds.
 If LESS than 1 day, --- hrs. or --- min.

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. None
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Ireland

10-NAME OF FATHER, Patrick McGuigan

11-BIRTHPLACE OF FATHER, (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, ANN Lagan

13-BIRTHPLACE OF MOTHER, (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John, P.M. Murphy.

(Address) 705 N. Broadway.

15- JUN 27 1915 ROBERT KRAUTER,

Filed. 1915.1.1. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 27, 1915.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 18th 1915, to June 27th 1915, that I saw him alive on June 26th 1915, and that death occurred, on the date stated above, at 19 m.

The CAUSE OF DEATH* was as follows:
 Acute Inflammation of the lungs

(Duration) yrs. mos. ds. 10

CONTRIBUTORY (Secondary) Inflammation of the lungs

(Duration) yrs. mos. ds.

(Signed) E. duane M.D.

June 27, 1915. (Address) 208 Myrtle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Burial

DATE OF BURIAL, June 29, 1915

20-UNDERTAKER, Ad. Coates & Son

ADDRESS, 1100 Mt. Royal Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *600 N Milton Ave* ST. *7* WARD)

FULL NAME

(Residence in Baltimore: No. *600 N Milton Ave* St.; yrs. mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED,

Married
(Write the word.)

6-DATE OF BIRTH,

Jan 22nd, 1868
(Month) (Day) (Year)

7-AGE,

47 yrs. *5* mos. *3* ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Plumber

9-BIRTHPLACE,
(State or Country),

Ills

10-NAME OF FATHER

Frederick Klaunberg

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Carrie Klaunberg

(Address)

600 N. Milton Ave

15-

JUN 27 1915

ROBERT KRAUTER

Filed

Marital Permit Office

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24th, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Probably Organic Heart Disease

(Signed) *Joseph S. Russell* M. D.

June 24, 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery June 27, 1915

20-UNDERTAKER

ADDRESS

Christian Miller 2334 Jefferson St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *Mary Hospital* ST. *22* WARD)
2-FULL NAME *Mary L. Kowski*
(Residence in Baltimore: No. *208 Church* St.; yrs., mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)
6-DATE OF BIRTH, *Sept. 30, 1911*
(Month) (Day) (Year)

7-AGE, *3* yrs., *10* mos., *—* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Md.*

10-NAME OF FATHER, *Louis J. Kowski*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *Helen Wittles*

13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louis J. Kowski*

(Address) *208 Church St.*

15- *JUN 27 1915* *ROBERT KRAUTER*

Filed *1915* *Permit 0* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *June 26, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry* find that said deceased came to her death *on the day stated above.*

The CAUSE OF DEATH was as follows:
Accidental Burns caused by catching fire of child's clothes by a lighted match of body and death.

(Duration) *2* yrs. *2* mos. *2* ds.

CONTRIBUTORY *Shock*
(Secondary)

(Duration) *2* yrs. *2* mos. *2* ds.

(Signed) *Wm. M. Savage* M. D.
(Coroner.)

June 27, 1915 (Address) *719 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs. *2* mos. *2* ds. In the State *2* yrs. *2* mos. *2* ds.

Where was disease contracted, if not at place of death? *at 208 Church St.*

Former or usual residence *208 Church St.*

19-PLACE OF BURIAL OR REMOVAL *St. Mary's* DATE OF BURIAL *June 28 1915*

20-UNDERTAKER *St. Mary's* ADDRESS *1318 Light St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 257 & Broadway ST.; 2 WARD)

2-FULL NAME

(Residence in Baltimore: No. 257 & Broadway St.; yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1b.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)6-DATE OF BIRTH, June 24th 1876
(Month) (Day) (Year)7-AGE, 39 yrs., mos., ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country). Wilmington A C10-NAME OF FATHER, John Hogan11-BIRTHPLACE OF FATHER (State or Country). Ireland12-MAIDEN NAME OF MOTHER Mary Welsh13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Winnie Perkins(Address) 257 & Broadway15-JUN 27 1915 ROBERT KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6 - 25, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Apr 30 1914, to June 23 1915, that I saw her alive on June 23 1915, and that death occurred, on the date stated above, at 2:00 m.

The CAUSE OF DEATH* was as follows:

Acute nephritis
(Duration) yrs. 2 mos. ds.CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.(Signed) J. E. Kelly M. D.
6 - 25, 1915. (Address) 111 & Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy CrossDATE OF BURIAL, June 28, 191520-UNDERTAKER, John A. Moran & Ann StADDRESS Bank

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Francis Stewart Hincks*(Residence in Baltimore: No. *Savannah* St.; yrs. mos. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*4-COLOR OR RACE, *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*6-DATE OF BIRTH, *Nov 29, 1872*

(Month)

(Day)

(Year)

7-AGE, *42*

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Canada*10-NAME OF FATHER, *Francis Hincks*11-BIRTHPLACE OF FATHER (State or Country), *Canada*12-MAIDEN NAME OF MOTHER *Alice Pollard*13-BIRTHPLACE OF MOTHER (State or Country), *West Indies*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Cecelia M. Hincks*(Address) *Rutherfordton, N.C.*

15-

JUN 27 1915

ROBERT KRAUTER

Filed

191

MAR 11 PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 26, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 11, 1915*, to *June 26, 1915*, that I saw him alive on *June 26, 1915*, and that death occurred, on the date stated above, at *9³⁰ A.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma Larynx(Duration) yrs. *10* mos. ds.CONTRIBUTORY (Secondary) *Operation Removal Throat & Larynx*(Duration) yrs. mos. ds. *4*(Signed) *J. M. Winston, M.D.**June 26, 1915* (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *15* ds. In the State yrs. mos. ds. *47*Where was disease contracted, if not at place of death? *unknown*Former or usual residence *Savannah Ga.*19-PLACE OF BURIAL OR REMOVAL, *Drews bury, N.C.*DATE OF BURIAL, *June 28, 1915*20-UNDERTAKER, *Joseph B. Cook*ADDRESS, *603 N. Baltimore*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86295

CERTIFICATE OF DEATH.

79 C86295
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2407 W Lombard ST. 20 WARD)

2-FULL NAME

George Lemm (Residence in Baltimore: No. 2407 W Lombard St.: 27 yrs., mos. da.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

W.C.T.5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Sept 24, 1893
(Month) (Day) (Year)

7-AGE,

22 yrs. 9 mos. 1 da. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Germany
Uckermark

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

Uckermark

12-MAIDEN NAME OF MOTHER

Uckermark

13-BIRTHPLACE OF MOTHER (State or Country),

Uckermark

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Heise(Address) 2407 W Lombard15- **JUN 27 1915** **ROBERT KRAUTER,**
Burial Permit Clerk

Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 15 1915, to June 25 1915, that I saw him alive on June 24 1915, and that death occurred, on the date stated above, at 12:30 m. The CAUSE OF DEATH* was as follows:Valvular Disease of Heart
(Duration) 2 yrs. mos. da.CONTRIBUTORY.....Rheumatism
(Secondary)(Duration) 6 yrs. mos. da.(Signed) Edw. Green M. D.June 26, 1915. (Address) 517 Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western View

DATE OF BURIAL,

June 27, 1915.

20-UNDERTAKER

Joseph L. Cook

ADDRESS

1003 N. Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86296

CERTIFICATE OF DEATH

64 C86296
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 3014 Presstman St. ST. 15 WARD)

FULL NAME Etta M. Webster

(Residence in Baltimore: No. 3014 Presstman St. St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(If write the word)

6. DATE OF BIRTH Nov 12, 1859
(Month) (Day) (Year)

7. AGE 55 yrs. 7 mos. 14 ds. or min. ? If LESS than 1 day, hrs.

8. OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country) Md.

10. NAME OF FATHER Wm. A. Dy

11. BIRTHPLACE OF FATHER (State or country) Md.

12. MAIDEN NAME OF MOTHER Laura Eichelberger

13. BIRTHPLACE OF MOTHER (State or country) Bald Mt.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. Frank Webster

(Address) Street Harford Co Md

15. JUN 27 1915 ROBERT KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 26, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14, 1915 to June 26, 1915, that I saw her alive on June 26, 1915, and that death occurred, on the date stated above, at 3:10 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Diffuse Nephritis
Arterio Sclerosis

(Duration) 5 yrs. mos. ds.
Contributory (SECONDARY) Cerebral Hemorrhage

(Signed) R. C. Mettel M. D.
June 26, 1915 (Address) 1903 W. North St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Harford Co Md June 28, 1915

20. UNDERTAKER ADDRESS

Wm. Moutrow 230 Greene

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86297

CERTIFICATE OF DEATH.

x 37 C86297

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. 7* ST.; WARD)

2-FULL NAME

(Residence in Baltimore: No. *13 Pulaski St. Cumberland Md.* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH.

unknown; 1
(Month) (Day) (Year)

7-AGE.

46 yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *P.P. Conductor*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. J. Curry*(Address) *13 Pulaski St.*

15- JUN 27 1915

ROBERT KRAUTER

Filed..... 191... Serial Permit Officer Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 27, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 22, 1915*, to *June 27, 1915*, that I saw him alive on *June 27, 1915*, and that death occurred, on the date stated above, at *10:50 a.m.*

The CAUSE OF DEATH* was as follows:

Typhoid fever
(Duration) *2* yrs. *7* mos. *—* ds.

CONTRIBUTORY (Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.(Signed) *John T. King Jr.* M. D.*June 27, 1915* (Address) *13 Pulaski St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *5* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *13 Pulaski St. Cumberland Md.*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Cumberland Md. June 27, 1915

20-UNDERTAKER.

ADDRESS

W. J. Schoeffel & Son 85 E. Lomb St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Kenneth A. Kelly Hospital* ST. *44* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Sarah Emma Armstrong*(Residence in Baltimore: No. *1418 Eutam Place* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

*Oct.**12**1858*

(Month)

(Day)

(Year)

7-AGE,

56 yrs. *8* mos. *19* ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

Teacher

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Phila.

PARENTS.

10-NAME OF FATHER,

Hugh Armstrong

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Robinson

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Wm. H. Z. Green

(Address).....

446 N. 4th St. 1st Floor

15-

ROBERT KRAUTER

JUN 27 1915

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*June 27**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 28**1915*, to *June 27**1915*that I saw her alive on *June 27* *1915*and that death occurred, on the date stated above, at *2 p.* m.

The CAUSE OF DEATH* was as follows:

*Cancer of Bladder**(Verified by operation)*

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

Excess

(Duration)..... yrs. mos. ds.

(Signed)..... *Robert H. Lewis* M. D.*June 27, 1915* (Address)..... *1418 Eutam Pl.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSPORTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death? *Trenton, N. J.*Former or usual residence *13 Ewing St. Trenton N.J.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Trenton N. J.**June 27, 1915*

20-UNDERTAKER

ADDRESS

Chas. G. Black 1201 W. Mulberry St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

86299

Harry Brown

HEALTH DEPARTMENT—CITY OF BALTIMORE

86299

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *University Hospital*) ST. *4* WARD)
FULL NAME *Harry Brown*
(Residence in Baltimore: No. *771 Vine*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yr., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*
4-COLOR OR RACE, *Black*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
6-DATE OF BIRTH, *Unknown*, 1883
(Month) (Day) (Year)
7-AGE, *32* yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), *Maryland (Baltimore)*
10-NAME OF FATHER, *Neuron Brown*
11-BIRTHPLACE OF FATHER (State or Country), *Mid*
12-MAIDEN NAME OF MOTHER *Lillie Brown*
13-BIRTHPLACE OF MOTHER (State or Country), *Mid*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *John Brown*
(Address) *771 Vine St.*

15-
Filed JUN 28 1915 HARRY C. A. REGISTRAR
191... Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 25th*, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said *Inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

THE CAUSE OF DEATH was as follows:
Lacerated and infected wound (gas bacillus) of left thigh as result of accident falling off of railroad car.

(Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) *gas bacillus infection*

(Signed) *Walter M. Savage*, M. D.
(Coroner)

June 26, 1915 (Address) *1719 W. Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. *3* ds. In the *32* yrs. ... mos. ... ds. State...

Where was disease contracted, if not at place of death? *at Curtis Bay Railroad yards.*

Former or usual residence *771 Vine St.*

19-PLACE OF BURIAL OR REMOVAL, *St. Johns Cemetery* DATE OF BURIAL, *June 25 1915*

20-UNDERTAKER *Daniel Eason* ADDRESS *716 Penna ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86300

CERTIFICATE OF DEATH.

151
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 726 Greenmount Ave ST. 10 WARD)

2-FULL NAME

(Residence in Baltimore: No. 726 Greenmount Ave St.; yrs. 9 mos. 4 da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

June 26, 1915
(Month) (Day) (Year)

7-AGE,

9 yrs. 9 mos. 4 da. 9 hrs. or 9 min. 7
If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer) None9-BIRTHPLACE,
(State or Country),Balt.

10-NAME OF FATHER,

Edgar Wagner11-BIRTHPLACE OF FATHER
(State or Country),Baltimore

12-MAIDEN NAME OF MOTHER

Esther May Both13-BIRTHPLACE OF MOTHER
(State or Country),Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Baublitz(Address) 726 Greenmount Ave

15-

JUN 28 1915

HARRY C. ANDERSON

Filed 1915 June 28 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 26, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 26 1915, to June 26 1915, that I saw him alive on June 26 1915, and that death occurred, on the date stated above, at 7:10 P.M.

The CAUSE OF DEATH* was as follows:

Respiratory Distress
(7 mos)(Duration) 9 hrs yrs. 9 mos. 4 da.CONTRIBUTORY
(Secondary)(Duration) 9 hrs yrs. 9 mos. 4 da.(Signed) R. Russell M. D.Cap. 7, 101.5 (Address) 807 Greenmount Ave

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 9 yrs. 9 mos. 4 da. In the State 9 yrs. 9 mos. 4 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baptist Cemetery June 28 1915

20-UNDERTAKER

ADDRESS

Henry Boeck's Son 1301 E. Eager

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86301

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *1012 Peach ally* ST. *23* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1012 Peach ally*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St.; *40* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED, *Widow*

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Feb 9, 1857
(Month) (Day) (Year)

7-AGE,

58 yrs. *4* mos. *16* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Launderess

9-BIRTHPLACE,

(State or Country),

Virginia

10-NAME OF FATHER,

George Scarborough

11-BIRTHPLACE OF FATHER

(State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Sarah Hutchinson

13-BIRTHPLACE OF MOTHER

(State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sadie Hicks*(Address) *1500 E. Fairmount Ave.*

15-

JUN 28 1915

HARRY O. ANDREWS

Filed

191

Serial

Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 9, 1915, to June 25, 1915,*that I saw her alive on *June 25, 1915,*and that death occurred, on the date stated above, at *8:45 P. m.*

The CAUSE OF DEATH* was as follows:

*Primary Paralysis**Immediate - Exhaustion*(Duration).....yrs.....mos.....*16* ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....*16* ds.(Signed) *A. D. Thompson* M. D.*June 27, 1915* (Address) *506 Hancock St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Mt Zion Cem**June 28, 1915*

20-UNDERTAKER

ADDRESS

John W. Henderson 317, Caroline

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86302

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86302

CERTIFICATE OF DEATH.

28

PLACE OF DEATH
CITY OF BALTIMORE (No. *1005 S. Robinson*)
ST. *1* WARD
FULL NAME *Elizabeth Woodward Stokes*
(Residence in Baltimore: No. *1005 S. Robinson*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *Life* mos. *da.*

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Female</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>Married</i> (Write the word.)
6-DATE OF BIRTH, <i>February 5th, 1872</i> (Month) (Day) (Year)		
7-AGE, <i>43</i> yrs. <i>4</i> mos. <i>20</i> ds. If LESS than 1 day, ...hrs. or...min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>None</i> (b) General nature of industry, business, or establishment in which employed (or employer). <i>At home</i>		
9-BIRTHPLACE, (State or Country), <i>Baltimore</i>		
PARENTS.	10-NAME OF FATHER, <i>Patrick Coleman</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Ireland</i>	
	12-MAIDEN NAME OF MOTHER <i>Bridget Shelley</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>va</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edwin Stokes*

(Address) *1005 S. Robinson St.*

15-
JUN 28 1915
FILED
191
HARRY C. ANDERSON,
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,
June 26th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said...
(Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Mental Insufficiency
(Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY... *Pulmonary Tuberculosis*
(Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) *David W. Jones* M. D.
(Coroner.)
June 26, 1915. (Address) *7116 S. O'Connell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, <i>St Peter</i>	DATE OF BURIAL, <i>June 29, 1915</i>
20-UNDERTAKER, <i>John J. Brown & Son</i>	ADDRESS <i>901 Hollins St</i>

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86303

C86303

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 Richmond ST.; 11 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 213 Richmond St.; — yrs., — mos., — ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Sept 1895, 1 (Month) (Day) (Year)

7-AGE,

68 yrs., — mos., — ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Crocheter

9-BIRTHPLACE, (State or Country),

Inguia

10-NAME OF FATHER,

John Brown

11-BIRTHPLACE OF FATHER (State or Country),

Inguia

12-MAIDEN NAME OF MOTHER

Mat Kead

13-BIRTHPLACE OF MOTHER (State or Country),

Mat Kead

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Esther Brown(Address) 213 Richmond St

15-

JUN 28 1915

Filed

191

1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25th, 1915. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 27th 1915, to June 25th 1915, that I saw him alive on June 25th 1915, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis terminating in uremic coma(Duration) Unknown yrs., — mos., — ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs., — mos., — ds.(Signed) Chas. J. Keller M. D.June 25th, 1915 (Address) 222 W. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

June 27th, 1915.

20-UNDERTAKER

John A. T. B. Co.

ADDRESS

1117

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Hospital* St.;

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Michael Riordan*(Residence in Baltimore: No. *26 E. Barney St.*

St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH,

Nov. 23, 1888
(Month) (Day) (Year)

7-AGE,

*26 yrs., 7 mos., 4 ds.*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Lab Worker*9-BIRTHPLACE,
(State or Country),*Vermont*

10-NAME OF FATHER,

*W. A. Riordan*11-BIRTHPLACE OF FATHER
(State or Country),*Vermont*

12-MAIDEN NAME OF MOTHER

*May Mornay*13-BIRTHPLACE OF MOTHER
(State or Country),*Vermont*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Michael Riordan

(Address).....

26 E. Barney St.

15-

JUN 28 1915

191

HARRY C. BIRD

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 27, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 21, 1915*, to *June 27, 1915*, that I saw her alive on *June 27, 1915*, and that death occurred, on the date stated above, at *7:40* m.

The CAUSE OF DEATH* was as follows:

*Laceration of Right Leg.
deceased - Struck by a chain from
a pulley. (Duration) 7 yrs., 7 mos., 7 ds.*CONTRIBUTORY
(Secondary)*Subcutaneous (Duration) 2 yrs., 2 mos., 2 ds.
(Signed) Elmer Newcomer, M. D.
6-27-1915 (Address) Union Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

26 E. Barney St.

19-PLACE OF BURIAL OR REMOVAL,

Roston, Mass.

DATE OF BURIAL,

June 28, 1915

20-UNDERTAKER

H. M. E. Lynn

ADDRESS

*1422 Light St.**over*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86306

CERTIFICATE OF DEATH.

39

PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *100* WARD)FULL NAME *Peter Nolan*(Residence in Baltimore: No. *2316 W Fayette* St.; *61* yrs., *3* mos., *14* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH.

Mar 12, 1854
(Month) (Day) (Year)

7-AGE.

61 yrs., *3* mos., *14* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Stone Cutter*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country), *W.D. Baltimore*10-NAME OF FATHER, *Peter Nolan*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER *Mary Johnson*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward H. H. H.*(Address) *Calvert St.*

15-

JUN 28 1915

HARRY C. ANDERSON,

Filed

1915

MARIAL F. W. H. GARY,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 26, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 23, 1915* to *June 26, 1915*,that I saw him alive on *June 26, 1915*and that death occurred, on the date stated above, at *5:30* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue
Operated Aug 24, 1915
*also (Duration) ... yrs. ... mos. ... ds.*CONTRIBUTORY (Secondary) *Surgical Shock**also (Duration) ... yrs. ... mos. ... ds.*(Signed) *Edward H. H. H.* M. D.*June 26, 1915* (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. *3* yrs., *3* mos., *14* ds. In the *Life* State *MD* yrs. *3* mos. *14* ds.Where was disease contracted, if not at place of death? *2316 W Fayette St.*Former or usual residence *2316 W Fayette St.*

18-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*New Cathedral**June 19, 1915*

20-UNDERTAKER

ADDRESS

*Joseph H. H. H.**1003 N. Calto*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86307

92

C86307

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3315 Chestnut Ave. ST. 13 WARD)

2-FULL NAME George E Basford

(Residence in Baltimore: No. 3315b Chestnut Ave. St. Life yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male	4-COLOR OR RACE White	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
6-DATE OF BIRTH Jan. 21 1910 (Month) (Day) (Year)	7-AGE 5 5 4 yrs. mos. ds. or min.?	
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None		

9-BIRTHPLACE
(State or country)

Baltimore City

PARENTS

10-NAME OF FATHER	Clinton B. Basford
11-BIRTHPLACE OF FATHER (State or country)	Frederick Md.
12-MAIDEN NAME OF MOTHER	Sarah E. Pearson
13-BIRTHPLACE OF MOTHER (State or country)	Carroll Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clinton B. Basford
(Address) 3315 Chestnut Ave.

15-

JUN 28 1915

HARRY O. ANDREWS

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

June 25 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 13, 1915 to June 25 1915, that I saw him alive on June 25 1915, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. mos. ds. 4
Contributory (SECONDARY) Pneumonia (Lobar)
(Signed) A. J. Davis M. D.
6 26 1915 [Address] 800 W 3rd St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL
Woodlawn Cemetery

DATE OF BURIAL
June 28 1915

20-UNDERTAKER

A. S. Marshall 3539 Falls Road

ADDRESS

C86308

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86303

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *St. Joseph Hospital* ST. *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Samuel Eccleston Eichelberger*(Residence in Baltimore: No. *Philadelphia Pa* St.; *2* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*4-COLOR OR RACE, *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *June 27*, 1877

(Month)

(Day)

(Year)

7-AGE, *38* yrs., *5* mos., *21* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Writer*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE (State or Country), *Baltimore Md*10-NAME OF FATHER, *Samuel E. Eichelberger*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore Md*12-MAIDEN NAME OF MOTHER, *Sophia Brittan*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sophia Eichelberger*(Address) *Phila Pa*

15-JUN 28 1915

HARRY O. ANDREWS

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 27*, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *June 2* 1915 to *June 27* 1915, that I saw him alive on *June 27* 1915, and that death occurred, on the date stated above, at *8:15 P* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach
(Operation).... (Duration).... yrs.... mos.... ds.

CONTRIBUTORY (Secondary).....

(Duration).... yrs.... mos.... ds.

(Signed) *G. B. Lynch* M. D.*June 27*, 1915 (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state the MEANS OF INJURY; and (a) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *Home*Former or usual residence *Phila Pa*19-PLACE OF BURIAL OR REMOVAL, *St. Mary's*DATE OF BURIAL, *June 30*, 191520-UNDERTAKER, *Chas. E. Evanson*ADDRESS, *115 W 4th St*

N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86309

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86309

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1036 Hanover* ST. *23* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1036 Hanover* St. *Lifeline* yrs. mos. ds.)

(If death occurred in a hospital or institution, give his NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

March 15th, 1846
(Month) (Day) (Year)

7-AGE,

69 yrs. 3 mos. 11 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Tailor*9-BIRTHPLACE,
(State or Country),*Baltimore Md.*

10-NAME OF FATHER,

*Sylvester Ruth.*11-BIRTHPLACE OF FATHER
(State or Country),*Germany.*

12-MAIDEN NAME OF MOTHER

*Not known*13-BIRTHPLACE OF MOTHER
(State or Country),*Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Magdalena Ruth*(Address) *1036 Hanover St.*

15-

Filed

JUN 28 1915 HARRY O. A. FEWIS,
191...*Serial 10197*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 26th, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *March 16th, 1915*, to *June 26th, 1915*, that I saw him alive on *June 25th, 1915*, and that death occurred, on the date stated above, at *139 A* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
(Primary or Secondary)(Duration) yrs. *6* mos. ds.CONTRIBUTORY
(Secondary)*Cardiac asthma*(Duration) yrs. *2* mos. ds.

(Signed)

H. J. Barrick M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral

DATE OF BURIAL,

June 29th, 1915.

20-UNDERTAKER

E. B. Hault

ADDRESS

115 E. North St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3032 Barclay ST.; 12 WARD)

2-FULL NAME

(Residence in Baltimore: No. 3032 Barclay St.; 35 yrs., 3 mos., 5 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and All out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH

Nov 28, 1866
(Month) (Day) (Year)

7-AGE

48 yrs., 6 mos., 29 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

House work

9-BIRTHPLACE, (State or Country),

Baltimore, Md

PARENTS.

10-NAME OF FATHER,

William W. Parsons

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Elizabeth Stiffler

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Grace Sanford

(Address)

3032 Barclay

JUN 28 1915

Filed..... 191

HARRY O. ANDREWS,

Burial Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 27, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 15 1915, to June 27 1915, that I saw her alive on June 25 1915, and that death occurred, on the date stated above, at 1220 P.M.

The CAUSE OF DEATH* was as follows:

Alophy / Cerebral Lobe

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.
(Signed) J. C. T. Adams M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Ave June 28, 1915

20-UNDERTAKER

ADDRESS

William Cook 502 E. North

N. B.—Every item of information should be carefully supplied. AGE, known or stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1522 N. Spring* ST.; *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James Wilson Smith*(Residence in Baltimore: No. *1522 N. Spring* St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

Sept. 7, 1892
(Month) (Day) (Year)

7-AGE,

*22 yrs. 9 mos. 19 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, business,
or establishment in which
employed (or employer).....*Train Agent*9-BIRTHPLACE,
(State or Country),*England*

PARENTS.

10-NAME OF
FATHER,*William Smith*11-BIRTHPLACE
OF FATHER
(State or Country),*England*12-MAIDEN NAME
OF MOTHER*Annie Wilson*13-BIRTHPLACE
OF MOTHER
(State or Country),*England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William H. Wilson*(Address) *1522 N. Spring St.*

15-

JUN 28 1915

HARRY O. ANDERSON,

Filed *1915* *Permit 01915*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 27, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 20 1915, to *June 27 1915*,that I saw him alive on *June 25 1915*,and that death occurred, on the date stated above, at *2 A* m.

The CAUSE OF DEATH* was as follows:

A. Tuberculosis (Pulmonary)(Duration) *3* yrs. *3* mos. *3* ds.CONTRIBUTORY
(Secondary)(Duration) *3* yrs. *3* mos. *3* ds.(Signed) *Walter W. White* M. D.*June 27, 1915* (Address) *1101 N. Spring St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *3* mos. *3* ds. In the State *3* yrs. *3* mos. *3* ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore City

DATE OF BURIAL,

June 28, 1915

20-UNDERTAKER

McNamee Cook

ADDRESS

5026 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86312

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86312

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1747 N. Chester* St.: *8* WARD)

REGISTERED No. C

2-FULL NAME *Sarah A. Heagy*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1747 N. Chester* St.: *8* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE

WIDOWED

WIDOWED

OR DIVORCED

(Write the word.)

6-DATE OF BIRTH,

Sept (Month) *20* (Day) *1824* (Year)

7-AGE,

90 yrs., *9* mos., *6* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work...

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)...

9-BIRTHPLACE,

(State or Country),

Pa

10-NAME OF FATHER,

Jacob Schirber

11-BIRTHPLACE OF FATHER

(State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Ruth Delany

13-BIRTHPLACE OF MOTHER

(State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ema C. Noor*

(Address) *1747 N. Chester St.*

15-

JUN 28 1915

HARRY O. ANDERSON

Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June (Month) *26* (Day) *1915* (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

(Shock) fall down Stairway (Accident)

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Elijah J. Russell* M. D.

(Coroner.)

June 27 1915. (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park

June 28 1915

20-UNDERTAKER

ADDRESS

William Cook

502 N. ...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

086313		HEALTH DEPARTMENT—CITY OF BALTIMORE		Jeffers Carroll Ave X159 086313	
PLACE OF DEATH		Lombard & Green		REGISTERED No. C	
CITY OF BALTIMORE (No. 1)		University Hospital St. 4		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
2-FULL NAME		Michael Meerget			
(Residence in Baltimore: No. 215 South 7th Street Highlandtown				St. yrs. mos. ds.)	
PERSONAL AND STATISTICAL PARTICULARS.					
3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)			
Male	White	Single			
6-DATE OF BIRTH,	7-AGE,				
Oct 30, 1884	30 yrs. 7 mos. 28 ds.				
		If LESS than 1 day, ...hrs. or...min.			
8-OCCUPATION:					
(a) Trade, profession, or particular kind of work.		Tailor			
(b) General nature of industry, business, or establishment in which employed (or employer).					
9-BIRTHPLACE, (State or Country),		Baltimore City			
10-NAME OF FATHER,		Anton Herget			
11-BIRTHPLACE OF FATHER (State or Country),		Baltimore City			
12-MAIDEN NAME OF MOTHER		Henrietta			
13-BIRTHPLACE OF MOTHER (State or Country),		Germany			
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.					
(Informant) Mrs. Mary Davis					
(Address) 215 S. 7th Street					
15- JUN 28 1915 HARRY O. ANDREWS, Registrar.					
CORONER'S CERTIFICATE OF DEATH.					
16-DATE OF DEATH, June 27, 1915					
(Month) (Day) (Year)					
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.					
The CAUSE OF DEATH* was as follows:					
Gun shot wound of brain (suicide)					
(Duration) yrs. mos. ds.					
CONTRIBUTORY (Secondary)					
(Duration) yrs. mos. ds.					
(Signed) J. P. Jeffers, M. D. (Coroner)					
101... (Address) 143 Carroll Ave					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).					
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.					
Where was disease contracted, if not at place of death?					
Brooklyn, N.Y.					
Former or usual residence, Highlandtown					
19-PLACE OF BURIAL OR REMOVAL			DATE OF BURIAL,		
Mt. Carmel			6/29/15		
20-UNDERTAKER			ADDRESS		
William Cook			502 E North Ave		

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86314

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86314

CERTIFICATE OF DEATH

31
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

802 S. Eutaw

ST.

22

WARD)

2-FULL NAME

Blanche Young

(Residence in Baltimore: No.

802 S. Eutaw

St. - yrs. - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female Colored

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7-AGE

20

yrs.

mos.

ds.

If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic

9-BIRTHPLACE
(State or country)

Md.

PARENTS

10-NAME OF FATHER

Ram Young

11-BIRTHPLACE OF FATHER
(State or country)

Md.

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER
(State or country)

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Gray

(Address)

802 S. Eutaw St

15-

JUN 28 1915

191

HARRY C. JENNINGS,

Sanial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 26, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1915, to June 26, 1915, that I saw h ~~er~~ alive on June 25, 1915, and that death occurred, on the date stated above, at 11⁰⁰ m.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(Duration) yrs. 6 mos. - ds.

Contributory
(SECONDARY)

(Duration) yrs. - mos. - ds.

(Signed)

H. S. M. East,

658

1915 [Address] 2005 Bond Street

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Auburn

June 28, 1915

20-UNDERTAKER

ADDRESS

A. L. Brown & Son 108 W. Mountz

C86315

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C86315

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407) ST. 3 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUN 28 1915

191. Serial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

191, to

191,

that I saw h. alive on 191,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemers,

June 28 1915.

20-UNDERTAKER

ADDRESS

Hendell Lippel Son

330 S. Bond St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Nos. 19* ST.: *19* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Monday Point Va.* St.: — yrs. — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*white*5-SINGLE, *married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Unknown, 1883
(Month) (Day) (Year)

7-AGE.

32 yrs. — mos. — ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country) *Northumberland Co Va*
H. U. Co Va

10-NAME OF FATHER.

J. J. Neal

11-BIRTHPLACE OF FATHER.

Northumberland Co Va
H. U. Co Va

12-MAIDEN NAME OF MOTHER.

Lucie Hambley

13-BIRTHPLACE OF MOTHER.

Northumberland Co Va
H. U. Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Warren L. King*(Address) *Monday Point Va.*

15-

JUN 28 1915 HARRY O. ANDREWS,
Filed 1915 Social Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 28, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 25*, 1915, to *June 28*, 1915, that I saw her alive on *June 28*, 1915, and that death occurred, on the date stated above, at *11:45 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Surgical shock
(Duration) ... yrs. ... mos. ... ds.
(Signed) *Geo. H. Smarr* M. D.
6/28, 1915 (Address) *Franklin Sq. Nos.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *3* ds. In the State yrs. mos. *3* ds.Where was disease contracted, if not at place of death? *at home*Former or usual residence *Monday Point Va.*

19-PLACE OF BURIAL OR REMOVAL.

Monday Pt. Va.

DATE OF BURIAL.

June 28, 1915

20-UNDERTAKER

Robt Brooks & Son Co

ADDRESS

Baltimore & Hollin-

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86317

79 C86317

CERTIFICATE OF DEATH

1 PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

John Cloake (Cloake)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No.

Little Sisters of the Poor

St.

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

Sept. 22, 1833
(Month) (Day) (Year)

7-AGE

81

yrs.

mos.

ds.

If LESS than

1 day, hrs.

or min?

8-OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

Ireland

PARENTS

10-NAME OF FATHER

Henry Cloake

11-BIRTHPLACE OF FATHER
(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Esther Dyle

13-BIRTHPLACE OF MOTHER
(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sister Benedict

(Address)

Little Sisters of the Poor

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

June 27, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I attended deceased from

no record 1915

that I saw him alive on *June 26, 1915*

and that death occurred, on the date stated above, at *9 a. m.*

The CAUSE OF DEATH* was as follows:

Valvular disease of heart
Unknown (Duration) yrs. mos. ds.

Contributory
(SECONDARY)

HTA (Duration) yrs. mos. ds.
(Signed) *H. D. Barnes* M. D.
June 27, 1915 [Address] *1133 Valley*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross Ceme. *June 29, 1915*

UNDERTAKER

ADDRESS

H.C. Wedgfield *914 Greenmount Ave.*

15-
JUN 28 1915

ROBERT KRAUT

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C86318

151 C86318

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; ... yrs. *3* mos. *da*)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Single*

6-DATE OF BIRTH,

February 17th, 1915
(Month) (Day) (Year)

7-AGE,

4 yrs. 9 mos. 9 da.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*England*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUN 28 1915

ROBERT KRAUTER

Marital Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 26, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 1st* 1915, to *June 25* 1915, that I saw him alive on *June 25* 1915, and that death occurred, on the date stated above, at *900 a.m.*

The CAUSE OF DEATH* was as follows:

Malnutrition(Duration) *3* yrs. *3* mos. *da.*CONTRIBUTORY *Cholera contagiosa*
(Secondary)(Duration) *1* yrs. *1* mos. *da.*(Signed) *Elmer G. Hall* M. D.*June 26, 1915* (Address) *1612 North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *3* mos. *da.* In the State *3* yrs. *3* mos. *9* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral**June 28, 1915*

20-UNDERTAKER

ADDRESS

M. F. Foley & Sons 606 Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Asylum* ST. *14* WARD)

FULL NAME

*Frederick Dayton*Residence in Baltimore: No. *St. Vincent's Asylum* St.: yrs. *2* mos. *8* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

April 4th, 1915
(Month) (Day) (Year)

7-AGE,

2 yrs. 2 mos. 21 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

England

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

Filed

JUN 28 1915

ROBERT KRAUTH

Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 1st 1915, to June 25 1915,*that I saw him alive on *June 25 1915,*and that death occurred, on the date stated above, at *10.30 P.m.*

The CAUSE OF DEATH* was as follows:

M. abnutrition and M. al. assimilation
(Duration) *2 yrs. 2 mos. 21 ds.*CONTRIBUTORY
(Secondary)(Duration) *2 yrs. 2 mos. 21 ds.*(Signed) *Elmer G. Hall* M. D.*June 26, 1915. (Address) 1617 P. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *2* mos. *8* ds. In the State yrs. *2* mos. *21* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral June 28, 1915

UNDERTAKER

ADDRESS

M. F. & Sons 606 Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86320

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 C86320

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 E North Ave. ST.; 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. 1803 E North Ave. St.; 8 yrs., 2 mos., 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)Married

6-DATE OF BIRTH,

Apr. 13, 1853
(Month) (Day) (Year)

7-AGE,

62 yrs., 2 mos., 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Plaster
Self

9-BIRTHPLACE,

(State or Country).

Balto City

10-NAME OF FATHER,

Maynard Glasman

11-BIRTHPLACE OF FATHER

(State or Country).

Balto City

12-MAIDEN NAME OF MOTHER

China Barrie

13-BIRTHPLACE OF MOTHER

(State or Country).

Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Sarah M. Glasman
(Address) 1803 E North Ave.

15-

JUN 28 1915

ROBERT KRAUTER

Marital Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 26, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1914, to June 26, 1915, that I saw him alive on June 26, 1915, and that death occurred, on the date stated above, at 10⁴⁵ a.m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis(Duration) 2 yrs., 6 mos., 6 ds.CONTRIBUTORY
(Secondary)(Duration) 2 yrs., 6 mos., 6 ds.(Signed) Edwin B. Tenby, M. D.June 28, 1915. (Address) 223 N. Barclay St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Lorraine Cemetery

DATE OF BURIAL,

June 29, 1915.

20-UNDERTAKER

Alfred E. Kulla 221 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86321

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86321

1-PLACE OF DEATH

79 REGISTERED NO. C

CITY OF BALTIMORE (No. 606 E 34th St. 9 WARD)

2-FULL NAME Philip D. Tucker

(Residence in Baltimore: No. 606 E 34th St. 50 yrs. 1 mos. 26 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6-DATE OF BIRTH

April 30th, 1859 (Month) (Day) (Year)

7-AGE

56 yrs. 1 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Retired Bookkeeper

9 BIRTHPLACE (State or country)

Washington D.C.

10-NAME OF FATHER

Enoch Brison Tucker

11-BIRTHPLACE OF FATHER (State or country)

Va.

12-MAIDEN NAME OF MOTHER

Susan Davis

13-BIRTHPLACE OF MOTHER (State or country)

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Alice D. Tucker

(Address)

606 E 34th St.

15 JUN 28 1915

ROBERT KRAUTER, Registrar

Filed 1915

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 26, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY. That I attended deceased from

Apr 1, 1905, to June 26, 1915.

that I saw him alive on June 26, 1915, and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart. Mitral Regurgitation

(Duration) 10 yrs. 1 mos. 26 ds.

Contributory Chronic Nephritis

(SECONDARY) Chronic Nephritis (Duration) 7 yrs. 8 mos. 26 ds.

(Signed) R. G. Strickland, M. D.

June 27, 1915 (Address) 632 Gough Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Bur.

DATE OF BURIAL

June 29, 1915

20-UNDERTAKER

E. Schloman & Son

ADDRESS

1039 Y. Anovitz St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86322

C86322

x 186

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *University Hospital* ST. *H* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Elkridge, Md. Cumberland* St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

Married

6-DATE OF BIRTH

Unknown, 1 (Month) (Day) (Year)

7-AGE

34

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Cabinetmaker*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country)

Cumberland, Md.

PARENTS.

10-NAME OF FATHER

Henry Rosenmeyer

11-BIRTHPLACE OF FATHER (State or Country)

Unknown

12-MAIDEN NAME OF MOTHER

Ainbister

13-BIRTHPLACE OF MOTHER (State or Country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louis Stein*

(Address) *Cumberland, Md.*

JUN 28 1915

ROBERT A. KRAUTER

Mutual Permit Clerk

Filled..... 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 28, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

THE CAUSE OF DEATH was as follows:
Fracture of Spine and ribs (both sides). Accident, a keyboard of an organ fell on his body while working on the instrument in a church. (Duration) ... yrs. ... mos. ... ds. *7*

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Mois M. Savage* M. D. (Coroner.)

June 28, 1915 (Address) *1729 Madison Ave.*

*State the DISEASE CAUSING DEATH or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? *at Elkridge, Md.*

Former or usual residence *Cumberland, Md.*

19-PLACE OF BURIAL OR REMOVAL

Cumberland, Md.

DATE OF BURIAL

June 28, 1915

20-UNDERTAKER

Geo. W. Little

ADDRESS

5316 Lombard

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86323

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86323

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Announced dead Mercy Hospital*
 CITY OF BALTIMORE (No. *5* ST. *5* WARD)
 2-FULL NAME *William Hughes*
 (Residence in Baltimore: No. *Levering House* St.; yrs., — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*
 6-DATE OF BIRTH, *1* (Month) *1* (Day) (Year)
 7-AGE, *55* yrs. mos. ds. If LESS than 1 day, hrs. or min.?
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Laborer*
 (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *city*

PARENTS.
 10-NAME OF FATHER, *?*
 11-BIRTHPLACE OF FATHER (State or Country), *?*
 12-MAIDEN NAME OF MOTHER *?*
 13-BIRTHPLACE OF MOTHER (State or Country), *?*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Foster*
 (Address) *2912 Orleans St.*

15- *JUN 29 1915*
 HARRY O. ANDERSON, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 28, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, or autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:
acute myocardial dilatation

(Duration) yrs. mos. ds.
 CONTRIBUTORY (Secondary) *Myocarditis - Alcohol*

(Signed) *Thos. R. Saunders* M. D.
 (Coroner.)
June 29, 1915 (Address) *18 W. Front St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery* DATE OF BURIAL, *June 30, 1915*

20-UNDERTAKER *Wm. C. Fuller* ADDRESS *221 N. Broadway*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *618 S. Washington* ST.; *2* WARD)

REGISTERED NO. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *618 S. Washington* St.; yrs. mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

June 19, 1913
(Month) (Day) (Year)

7-AGE,

9
..... yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Ind. Arms Arundel*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), *Ind*

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Weber*(Address) *1618 S. Washington*

15-

JUN 29 1915

HARRY O. ANDERSON

Regist. *1618 S. Washington*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 28, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *June 28* 191*5*, to *June 28* 191*5*, that I saw h*er* alive on *1* 191*5*, and that death occurred, on the date stated above, at *11 P.* m.

The CAUSE OF DEATH* was as follows:

Insanition
(Duration)..... yrs. mos. *9* ds.

CONTRIBUTORY (Secondary)

(Signed) *Jacob L. Winner* M. D.
6-29 191*5* (Address) *30 S. B'way*

*State the DISEASE CAUSING DEATH, or, in deaths from VICARIOUS CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

June 29, 1915

20-UNDERTAKER

M. T. Sadowski

ADDRESS

705 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

086325

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 N. Eden ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 702 N. Eden St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Caucasian5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

Unknown 1 (Month) (Day) (Year)

7-AGE,

41 yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Cook

9-BIRTHPLACE, (State or Country),

Va.

PARENTS.

10-NAME OF FATHER,

William Stevens

11-BIRTHPLACE OF FATHER (State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Danielle Carter

13-BIRTHPLACE OF MOTHER (State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George M. Stevens(Address) 578 N. Eden St.

15- JUN 29 1915 HARRY O. ANDREWS,

Filed..... 1915 Serial Permit 012 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 29, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 16, 1915, to June 29, 1915, that I saw her alive on June 28, 1915, and that death occurred, on the date stated above, at 6-10 A.m.

The CAUSE OF DEATH* was as follows:

Acute Dysentery?

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac atrophy

(Duration)..... yrs. mos. ds.

(Signed) R. C. Robinson M. D.629 N. E. St. (Address) 611 N. Camden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Abney Cem

DATE OF BURIAL,

July 1, 1915

20-UNDERTAKER

Harry A. Bodony

ADDRESS

725 E. E. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *725 Cumberland* ST.;

ST.;

WARD)

15² REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. *725 Cumberland* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH

June 29, 1915
(Month) (Day) (Year)

7-AGE

5 1/2 mo fetus
yrs. mos. ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country)

725 Amb. St. Baltimore Md.

10-NAME OF FATHER

Edgar Youngling

11-BIRTHPLACE OF FATHER

Berroll Co Md.

12-MAIDEN NAME OF MOTHER

Mrs. Alice Biggs

13-BIRTHPLACE OF MOTHER

Bacon

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Edgar Youngling

(Address)

725 Cumberland St.

15-

*JUN 29 1915**HARRY O. ANDREWS*

Filed

191. Burial Permit. Cl...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH

June 29, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 29, 1915*, to *June 29, 1915*, that I saw him live on *June 29, 1915*, and that death occurred, on the date stated above, at *3:45 p.m.*

The CAUSE OF DEATH* was as follows:

Spontaneously due to marginal placenta previa. (live about 5 minutes).

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Madness

(Duration) yrs. mos. ds.

(Signed)

E. E. Smith M. D.*June 29, 1915. (Address) 1605 North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Western Cemetery**June 29, 1915*

20-UNDERTAKER

ADDRESS

*William Cook**1605 North Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *608 N. Chester* ST. *7* WARD)FULL NAME *John L. Rasch*(Residence in Baltimore: No. *608 N. Chester* St. *Life time* yrs., *Life time* mos., *Life time* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE. *White*5-SINGLE *Married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word.)6-DATE OF BIRTH *September 2nd, 1867*

(Month)

(Day)

(Year)

7-AGE. *47 9 24*

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession or particular kind of work. *My work is Mucker*(b) General nature of industry, business, or establishment in which employed (or employer). *Retired*9-BIRTHPLACE.
(State or Country). *Balt. Md.*10-NAME OF FATHER *Harold F. Rasch*11-BIRTHPLACE OF FATHER
(State or Country). *Balt. Md.*12-MAIDEN NAME OF MOTHER *Frances V. Hazard*13-BIRTHPLACE OF MOTHER
(State or Country). *Calvert Co. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). *Wesley Rasch*(Address). *608 N. Chester St.*

15-

JUN 29 1915

HARRY O. ANDREWS,

Bureau of Health, Baltimore, Md.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *June 26th, 1915*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *June 26th, 1915*that I saw him alive on *June 26th, 1915*and that death occurred, on the date stated above, at *11:20 a.m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) *2* yrs. *2* mos. *2* ds.

CONTRIBUTORY (Secondary)

High blood pressure
(Duration) *10* yrs. *10* mos. *10* ds.
John L. Meyer
1030 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *10* yrs. *10* mos. *10* ds. In the State *10* yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Balto. Md.*DATE OF BURIAL, *June 29, 1915*20-UNDERTAKER *Geo M. Fink*ADDRESS *811 N. Wolfe*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86328

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86328

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. *Ma General Hospital* 18 WARD)

2-FULL NAME *Sam L. Gao*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No. *103 N. Carrollton Ave.* St. *10* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male*

4-COLOR OR RACE *Mongolian*

5-SINGLE *Married*
MARRIED
DIVORCED
(Write the word)

6-DATE OF BIRTH *Unknown* 18*67*

(Month) (Day) (Year)

7-AGE *about* 48

If LESS than

1 day, hrs.,

yrs. — mos. — ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work *Laundryman*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *China*

PARENTS

10-NAME OF FATHER *Gang Jan*

11-BIRTHPLACE OF FATHER (State or country) *China*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or country) *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Joe Wing*

(Address) *103 N. Carrollton Ave.*

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *June 27th* 19*15*

(Month) (Day) (Year)

15- I HEREBY CERTIFY, That I attended deceased from *June 28th 1915* to *June 27th 1915*,

that I saw him alive on *June 27th 1915*, and that death occurred, on the date stated above, at *8 P. m.*

The CAUSE OF DEATH* was as follows:

Socomotor Ataxia

Contributory (SECONDARY) *over 2 yrs. — mos. — ds. Broncho Pneumonia*

(Signed) *Henry C. Oble* M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *4 hrs.* in the *10* yrs. *—* mos. *—* ds.

Where was disease contracted, If not at place of death?

Former or usual residence *103 N. Carrollton Ave.*

17-PLACE OF BURIAL OR REMOVAL *Baltimore City*

DATE OF BURIAL *July 4th* 19*15*

18-UNDERTAKER *Wm. Mitchell*

ADDRESS *No. 1201 Fayette*

JUN 29 1915

HARRY O. ANDREWS,

Registrar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86329

151

C86329

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 737 S. Montford Ave. ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 737 S. Montford St. 1 yrs. 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH June 29, 1915
(Month) (Day) (Year)

7-AGE 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 0 hrs. 0 min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto Md

10-NAME OF FATHER Char P. Yost

11-BIRTHPLACE OF FATHER (State or country) Md.

12-MAIDEN NAME OF MOTHER Ethel Schaffer

13-BIRTHPLACE OF MOTHER (State or country) Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Char P. Yost
(Address) 737 S. Montford Ave

15- JUN 29 1915 HARRY O. ANDREWS,
Funeral Permit Clerk,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 29, 1915 to June 29, 1915, that I saw him alive on June 29, 1915, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(7 mo)

Contributory (SECONDARY) None
(Signed) Charles Heer M. D.
June 29, 1915 [Address] 408 S. Montford Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 0 yrs. 0 mos. 0 ds. In the 0 yrs. 0 mos. 0 ds. State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL June 29, 1915

20-UNDERTAKER Wanda & Son ADDRESS 1710 E. Ave. 16

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86330

CERTIFICATE OF DEATH

53

C86330

PLACE OF DEATH

CITY OF BALTIMORE (No. *510 W. Stricker* ST. *19* WARD)

FULL NAME

(Residence in Baltimore: No. *510 W. Stricker St.* St. *43* yrs. *5* mos. *23* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

Jan 5, 1872
(Month) (Day) (Year)

7-AGE

43 yrs. *5* mos. *23* ds. or — min.?
If LESS than 1 day, — hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Salesman

9-BIRTHPLACE

(State or country)

Balto. Md.

10-NAME OF FATHER

Philip Lang

11-BIRTHPLACE OF FATHER

Germany

12-MAIDEN NAME OF MOTHER

Columbine Brown

13-BIRTHPLACE OF MOTHER

Balto. Md. America

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter B. Lang

(Address)

Edliott City, Md.

15-

JUN 29 1915

HARRY O. ANDREWS,

Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 28, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1, 1914, to June 28, 1915.

that I saw him live on *June 28, 1915.*

and that death occurred, on the date stated above, at *4:25* m.

The CAUSE OF DEATH* was as follows:

Scurfaemia

About (Duration) *1 year* yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), *E. Miles Wheeler* M. D.

June 29, 1915 (Address) *2129 16th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cemetery June 30, 1915

20-UNDERTAKER

George J. Smith

ADDRESS

Capitol Hill

C86331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S Durham ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Edna Weiner(Residence in Baltimore: No. 119 S Durham St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Infant

6-DATE OF BIRTH,

November 28, 1914
(Month) (Day) (Year)

7-AGE,

7 yrs. 4 mos. 1 da.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None Infant9-BIRTHPLACE,
(State or Country),Baltimore Md.

PARENTS.

10-NAME OF FATHER,

Frank Weiner11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Pauline Hertzog13-BIRTHPLACE OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Weiner(Address) 119 S Durham St.

15-

JUN 9 1915

HARRY O. ANDREWS,

Filed 191 Serial 2 Permit 1 Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 28, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I attended deceased from June 19 1915 to June 28 1915, that I saw her alive on June 28 1915, and that death occurred, on the date stated above, at 7 am.

The CAUSE OF DEATH* was as follows:

Cholera Infantum(Duration)....yrs....mos....9 ds.CONTRIBUTORY
(Secondary)

(Duration)....yrs....mos....ds.

(Signed)

W. J. Francis M. D.621 S. 24th St. (Address) 1915

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer Ch. June 28 1915

20-UNDERTAKER

ADDRESS

Winchell Shippel & Son 37 S. Cum St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86332

C86332

PLACE OF DEATH

CITY OF BALTIMORE (No. 1017 Brantly Ave ST. 16 WARD)

FULL NAME

Leon Kahlenstein

(Residence in Baltimore: No. 1017 Brantly Ave St. 12 yrs. 4 mos. 14 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Feb 14

(Month)

(Day)

1902

(Year)

7-AGE

12

yrs.

4

mos.

14

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

School boy

9-BIRTHPLACE

(State or country)

Baltimore

10-NAME OF FATHER

Mr Kahlenstein

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Betty Frank

13-BIRTHPLACE OF MOTHER
(State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Max Kahlenstein

(Address)

1017 Brantly Ave

15.

JUN 29 1915

HARRY O. ANDREWS,

Barial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

(Month)

28th

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 17th, 1915, to, June 28, 1915,

that I saw him alive on June 28th, 1915,

and that death occurred, on the date stated above, 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration)

yrs.

mos.

2 7/8

Contributory
(SECONDARY)

Pyæmia

(Duration)

yrs.

mos.

5

(Signed)

J. Van Milligen M. D.

June 28, 1915

(Address)

611 Garrison St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Balto Schew

DATE OF BURIAL

June 30, 1915

20-UNDERTAKER

ADDRESS

J. Andrews & Co

1611 Madison

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86333 CERTIFICATE OF DEATH.

152 C86333
REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *West End Maternity No. 49* ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Infant Martin*(Residence in Baltimore: No. *406 N Parrish St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male*4-COLOR OR RACE, *Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word)

6-DATE OF BIRTH,, 1

(Month)

(Day)

(Year)

7-AGE,

yrs. mos. da.

If LESS than 1 day.

7 hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balt Md.*

PARENTS.

10-NAME OF FATHER, *Clarence Martin*11-BIRTHPLACE OF FATHER (State or Country), *Balt Md.*12-MAIDEN NAME OF MOTHER *Amelia Pasco*13-BIRTHPLACE OF MOTHER (State or Country), *Balt Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUN 29 1915

ROBERT . KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 27, 1915*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 27, 1915*, to *June 27, 1915*, that I saw him alive on *June 27, 1915*, and that death occurred, on the date stated above, at *7 a. m.*

The CAUSE OF DEATH* was as follows:

Asphyxia from Prolonged Asphyx.
(Duration) .. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) .. yrs. mos. ds.

(Signed) *Geo. H. Suman* M. D.*627, 1915* (Address) *Franklin Sq. No. 8.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .. yrs. mos. ds. In the State .. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *COLLEGE OF P. & S.*DATE OF BURIAL *JUN 29 1915*20-UNDERTAKER *Health.*

ADDRESS

FOR ANATOMICAL PURPOSES.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 2010 Druidhill ave. ST. 14 WARD)

2-FULL NAME Ernest Mason,

(Residence in Baltimore: No. 2010 Druidhill ave. St.; yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, June 28th, 1915. (Month) (Day) (Year)

7-AGE, 0 yrs., 0 mos., 3 hours, If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Walter Roy, 11-BIRTHPLACE OF FATHER, (State or Country), Unknown, 12-MAIDEN NAME OF MOTHER, Mamie Mason, 13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Mamie Mason, mother, (Address) 2010 Druidhill avenue.

15-ROBERT . KRAUTH, Registrar, JUN 29 1915, Filed

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28th, 1915. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Premature birth, (6 months utero-gestation) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) J. Frederick Hampel, M. D. (Signed) (Coroner.) June 29, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, JUN 29 1915

20-UNDERTAKER, Commissioner Health, ADDRESS

FOR ANATOMICAL PURPOSES

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86335

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hospital* ST.; *3* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence) in Baltimore: No. *215 Herring Court* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*Colored*5-SINGLE, *widower*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

unknown, 1
(Month) (Day) (Year)

7-AGE,

76 yrs. mos. ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*carpenter
ship-yards*9-BIRTHPLACE,
(State or Country),*unknown*

PARENTS.

10-NAME OF FATHER,

*unknown*11-BIRTHPLACE OF FATHER
(State or Country),*unknown*

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

*JUN 29 1915**ROBERT KRAUTER**BURIAL PERMIT OFFICE*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24, 1915,
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 18 1915, to *June 24* 1915,that I saw him alive on *June 24* 1915,and that death occurred, on the date stated above, at *6 P* m.

The CAUSE OF DEATH* was as follows:

*Chronic Interstitial
Nephritis*

(Duration)..... yrs. mos. ds.

CONTRIBUTORY. *Arterio-sclerosis*
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *Emmet M. Reiser* M. D.*June 24*, 1915. (Address) *St Josephs Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds. *X*

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*HOPKINS HOSPITAL**JUN 26 1915*

20-UNDERTAKER

ADDRESS

Commissioner Health

FOR ANATOMICAL PURPOSES.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86336 CERTIFICATE OF DEATH.

37 C86336
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. ST. 17* WARD)

2-FULL NAME

Baby Johnson.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *723 Bradley St.*St.; *—* yrs., *—* mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*Blk.*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

June
(Month)*17*, *1915*
(Day) (Year)

7-AGE,

— yrs., *—* mos. *10* ds.

If LESS than 1 day.

— hrs. or *—* min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),*Ind.*

10-NAME OF FATHER,

*Hamilton Green*11-BIRTHPLACE OF FATHER
(State or Country),*Ind.*

12-MAIDEN NAME OF MOTHER

*Beatrice Johnson*13-BIRTHPLACE OF MOTHER
(State or Country),*Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

*JUN 29 1915**ROBERT**JOHNS**HOPKINS HOSPITAL*

20-UNDERTAKER

Commissioner

DATE OF BURIAL

JUN 27, 1915

ADDRESS

FOR ANATOMICAL PURPOSES.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June
(Month)*26*, *1915*
(Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *June 17* 1915, to *June 26*, 1915, that I saw her alive on *June 26* 1915, and that death occurred, on the date stated above, at *1 A.* m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed).....

June 27, 1915 (Address)..... *C. S. Glass* M. D. *J. H. H.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. mos. *10* ds. In the State *—* yrs. mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

HOPKINS HOSPITAL

20-UNDERTAKER

Commissioner

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86337
CERTIFICATE OF DEATH.x 92
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin St. 2405* ST. *19* WARD)FULL NAME *Walter Mac Neary*

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

(Residence in Baltimore: No. *St. Louis Mo* St. *53* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

male

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Married*

6-DATE OF BIRTH,

unknown, 1 (Month) (Day) (Year)

7-AGE,

53 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Robot

9-BIRTHPLACE, (State or Country),

unknown

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUN 29 1915

ROBERT J. KRAUTER,

Filed..... 101..... Registrar.

20-UNDERTAKER

Commissioner Health.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25, 191*5* (Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *May 30* 191*5*, to *June 25* 191*5*, that I saw him alive on *June 25* 191*5*, and that death occurred, on the date stated above, at *6 P.* m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia(Duration) yrs. mos. ds. *25*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. *15*(Signed) *Geo. H. Quinn* M. D.*June 26*, 191*5* (Address) *Franklin St. 2405*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds. *25*

Where was disease contracted, if not at place of death?

Former or usual residence

At Home
24 Louis Mo

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

BETHLEHEM HOSPITAL

JUN 28 1915

ADDRESS

FOR ANATOMICAL PURPOSES.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86338

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland Gen'l Hosp.* ST.; *5* WARD)

2-FULL NAME

(Residence in Baltimore: No. *244 N. Exeter* St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female.* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, *married*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *October 25th*, 1878
(Month) (Day) (Year)

7-AGE, *36* yrs., mos., ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Housewif.*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Balto md*

10-NAME OF FATHER, *James Rogers*

11-BIRTHPLACE OF FATHER (State or Country), *Balto md*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Balto md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. A. Albrecht*
(Address) *1844 N. Durham St.*

15-*JUN 29 1915* *ROBERT KRAUTER,*
Filed..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 27*, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 23*, 1915, to *June 27*, 1915, that I saw her alive on *June 27*, 1915, and that death occurred, on the date stated above, at *6:30 P.m.*

The CAUSE OF DEATH* was as follows:
diffuse Peritonitis

(Duration)..... yrs..... mos..... ds.
CONTRIBUTORY... *gangrenous appendicitis*...
(Secondary) (Duration)..... yrs..... mos..... ds.

(Signed) *C. W. Myers* M. D.
June 27, 1915. (Address) *Maryland Gen'l Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? *?*

Former or usual residence *244 N. Exeter St.*

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer Cemetery* DATE OF BURIAL, *June 29 1915.*

20-UNDERTAKER, *McGinnis & Carroll* ADDRESS, *608 N. Potomac St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 S. Linwood ST., 1 WARD)

2-FULL NAME

(Residence in Baltimore: No. 517 S. Linwood Ave. yrs. mos. ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)Married

6-DATE OF BIRTH.

Male 29th, 1880
(Month) (Day) (Year)

7-AGE.

35 yrs. 2 mos. 28 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Tobacco
(b) General nature of industry, business, or establishment in which employed (or employer). acid works9-BIRTHPLACE,
(State or Country).Balto. Md.

10-NAME OF FATHER,

John F. Finnerly11-BIRTHPLACE OF FATHER
(State or Country).Balto. Md.

12-MAIDEN NAME OF MOTHER

Margaret Conroy13-BIRTHPLACE OF MOTHER
(State or Country).N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Finnerly(Address) 517 S. Linwood Ave

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June, 26, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan. 21 1915, to June 24 1915that I saw him alive on Jan. 24 1915and that death occurred, on the date stated above, at 8:30 in.

The CAUSE OF DEATH* was as follows:

Pulmonary and
Laryngeal Tuberculosis(Duration) 6 yrs. 6 mos. 6 ds.CONTRIBUTORY
(Secondary)(Duration) 1 yrs. 1 mo. 1 ds.(Signed) M. L. Burke M. D.June 25, 1915 (Address) 3042 Henderson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

New Cathedral June 30th, 1915

20-UNDERTAKER

ADDRESS

Lilly & Ziehl 403 S. Wolfe St.

15-

JUN 29 1915 ROBERT KRAUTFiled... 191... Burial Permit Clor Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2906 Brighton ST.; 16 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2906 Brighton St.; 63 yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIEDWidow

(Write the word.)

6-DATE OF BIRTH,

June 28th, 1852
(Month) (Day) (Year)

7-AGE,

63 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....Housework

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country), Baltimore

10-NAME OF FATHER,

John Lentz

11-BIRTHPLACE OF FATHER,

(State or Country), Baltimore

12-MAIDEN NAME OF MOTHER

Mary Hoodman

13-BIRTHPLACE OF MOTHER

(State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rufus Lentz(Address) 2906 Brighton St

15-

Filed JUN 29 1915 ROBERT KRAUTER
MAY 1st Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 28, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 1915, to June 1915,that I saw he alive on June 27 1915,and that death occurred, on the date stated above, at 54 m.

The CAUSE OF DEATH* was as follows:

Acute - pneumonia

.....

.....

..... (Duration) 1 yrs. mos. ds.

CONTRIBUTORY

(Secondary) apoplexy..... (Duration) 2 yrs. mos. 2 ds.(Signed) J. Frederick Lentz M. D.6/29, 1915 (Address) 2040 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cem

DATE OF BURIAL,

July 1st, 1915.

20-UNDERTAKER

Robt Brooks & Son

ADDRESS

Canton & W. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86341

CERTIFICATE OF DEATH.

REGISTERED No. C.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *418 S. Duncan* ST.: *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME

(Residence in Baltimore: No. *418 S. Duncan* St.: *7* yrs., *4* mos., *16* ds.)*Frances Guzikoska*

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE

MARRIED

OR DIVORCED

(Write the word.)

Single

6. DATE OF BIRTH

Feb. 12, 1908
(Month) (Day) (Year)

7. AGE

7 yrs., *4* mos., *16* ds.If LESS than 1 day,
...hrs. or...min.

8. OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9. BIRTHPLACE,
(State or Country).*Baltimore*

PARENTS.

10. NAME OF FATHER

*John Guzikoski*11. BIRTHPLACE OF FATHER
(State or Country).*Germany*

12. MAIDEN NAME OF MOTHER

*Mary Zacharski*13. BIRTHPLACE OF MOTHER
(State or Country).*Germany*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Guzikoska*(Address) *418 S. Duncan*

15.

*JUN 29 1915**ROBERT KRAUTER**NOTARY PUBLIC*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 28, 1915
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *May 18, 1915* to *June 28, 1915*, that I saw him alive on *June 28, 1915*, and that death occurred, on the date stated above, at *9 P* m.

The CAUSE OF DEATH* was as follows:

Acute Arterial Phlebotomy(Duration) *2* yrs., *3* mos., *16* ds.CONTRIBUTORY
(Secondary)*Endocarditis*(Duration) *2* yrs., *3* mos., *16* ds.(Signed) *Wm. A. J. Guzikoski* M. D.
June 29, 1915 (Address) *1900 E. Eastern Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *7* yrs., *4* mos., *16* ds. In the State *7* yrs., *4* mos., *16* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Holy Trinity

DATE OF BURIAL

June 30, 1915

20. UNDERTAKER

William Frazer

ADDRESS

1618 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86342

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 C86342

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *13 W Church*)

ST.: *22* WARD)

REGISTERED NO. C

2 FULL NAME

Parah Dennis

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *13 W Church*)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) *Married*

6 DATE OF BIRTH

Unknown, *1*

(Month) (Day) (Year)

7 AGE

42

If LESS than 1 day,

hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

9 BIRTHPLACE

(State or Country)

Unknown

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or Country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant: *J. Dennis*)

(Address: *13 W Church*)

JUN 30 1915

HARRY O. ANDERSON,

Filed, 1915

Marial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH

June 28, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Aphasia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Edw. G. Gump* M. D.

(Coroner.)

June 28, 1915 (Address) *517 S. 4th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Auburn *June 30, 1915*

20 UNDERTAKER

ADDRESS

J. L. Brownson *108 N. Montpelier*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *750 Waesche* ST.; *4* WARD)2-FULL NAME *George Albert Green*(Residence in Baltimore: No. *750 Waesche* St.;yrs., *1* mos. ds)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *Col.*5-SINGLE, MARRIED, WIDOW, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Feb. 29, 1880*

(Month)

(Day)

(Year)

7-AGE, *35* yrs., *4* mos.,ds.

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Driver*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Ind*10-NAME OF FATHER, *Edw Green*11-BIRTHPLACE OF FATHER (State or Country), *Ind*12-MAIDEN NAME OF MOTHER *Oteria Kelsey*13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*James Rowlings*(Address).....*750 Waesche St.*

JUN 30 1915

Filed....., 1915

HARRY O. ANDREWS,

Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 28, 1915*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *June 5* 1915, to *June 28* 1915, that I saw him alive on *June 26* 1915, and that death occurred, on the date stated above, at *7¹⁵* a.m.

The CAUSE OF DEATH* was as follows:

*Pulmonary Tuberculosis*CONTRIBUTORY (Secondary).....*Exhaustion*(Signed).....*J. H. Hughes*

June 28 1915

(Address).....*1413 D St. N.W.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Laurie Cemetery*DATE OF BURIAL, *July 30, 1915*20-UNDERTAKER, *Geo H Spooner*ADDRESS, *609 Little Rock St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86344

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86344

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST: *3* WARD)2-FULL NAME *Yetta Cohen*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

Residence in Baltimore: No. *205 Albermarle St.* St.; *6* yrs. *6* mos. *ds.*

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE

single~~WIDOWED~~~~DIVORCED~~

(Write the word)

6-DATE OF BIRTH

*Dec**1914*

(Month)

(Day)

(Year)

7-AGE

6

If LESS than

1 day, *hrs.*

yrs.

mos.

ds.

or min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

None

9-BIRTHPLACE

(State or country)

Balto Md.

10-NAME OF FATHER

Bennie Cohen

11-BIRTHPLACE OF FATHER (State or country)

Russia

12-MAIDEN NAME OF MOTHER

Fannie Bernstein

13-BIRTHPLACE OF MOTHER (State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bennie Cohen

(Address)

205 Albermarle St

15-

JUN 30 1915

191

HARRY O. ANDREWS,

Bureau of Health

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*June**29*, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 28, 1915, to, *June 29*, 1915,that I saw her alive on *June 29*, 1915,and that death occurred, on the date stated above, at *6:00* m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration)

yrs.

mos.

ds.

Contributory (SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

M. B. Levin

M. D.

June 29, 1915

(Address)

Hebrew Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Home

Former or usual residence

205 Albermarle St

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Hebrew Mt Carmel**June 30*, 1915

20-UNDERTAKER

ADDRESS

*S. Lunsford**1107 E Balto St*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Presbury

ST.: 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Grace Viola Bennis

(Residence in Baltimore: No. 1608 Presbury St.

St.: 15 yrs., 5 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Jan 22, 1900

(Month)

(Day)

(Year)

7-AGE,

15 yrs., 5 mos. 7 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Maryland (Balto City)

PARENTS.

10-NAME OF FATHER,

William Bennis

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Lettie Bishop

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Bennis

(Address) 1608 Presbury St

15-

JUN 30 1915

HARRY O. ANDREWS,

Filed 191. Burial Permit Clerk's Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 29, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 13, 1915, to June 29, 1915.

that I saw her alive on June 29, 1915, and that death occurred, on the date stated above, at 4:50 AM

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) 3 weeks 2 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. E. MacPone M. D.

6/29/15, 1915. (Address) 1900 Franklin Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Marlborough

DATE OF BURIAL,

July 1, 1915

20-UNDERTAKER

John H. Owens

ADDRESS

1222 Penn St

A. E. MacPone M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86346

C86346

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *10* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1001 Ensor St.* St.; *5* yrs., *7* mos., *5* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH.

Don't know, 1 (Month) (Day) (Year)

7-AGE.

48 yrs., *7* mos., *5* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Minister*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Va.

PARENTS.

10-NAME OF FATHER.

William Johnson

11-BIRTHPLACE OF FATHER (State or Country).

Va.

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER (State or Country).

Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Phelps*(Address) *Johns Hopkins Hosp.*

15-

JUN 30 1915

HARRY O. ANDREWS,

1915-1916-1917-1918-1919-1920-1921-1922-1923-1924-1925-1926-1927-1928-1929-1930-1931-1932-1933-1934-1935-1936-1937-1938-1939-1940-1941-1942-1943-1944-1945-1946-1947-1948-1949-1950-1951-1952-1953-1954-1955-1956-1957-1958-1959-1960-1961-1962-1963-1964-1965-1966-1967-1968-1969-1970-1971-1972-1973-1974-1975-1976-1977-1978-1979-1980-1981-1982-1983-1984-1985-1986-1987-1988-1989-1990-1991-1992-1993-1994-1995-1996-1997-1998-1999-2000-2001-2002-2003-2004-2005-2006-2007-2008-2009-2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025-2026-2027-2028-2029-2030-2031-2032-2033-2034-2035-2036-2037-2038-2039-2040-2041-2042-2043-2044-2045-2046-2047-2048-2049-2050-2051-2052-2053-2054-2055-2056-2057-2058-2059-2060-2061-2062-2063-2064-2065-2066-2067-2068-2069-2070-2071-2072-2073-2074-2075-2076-2077-2078-2079-2080-2081-2082-2083-2084-2085-2086-2087-2088-2089-2090-2091-2092-2093-2094-2095-2096-2097-2098-2099-2100-2101-2102-2103-2104-2105-2106-2107-2108-2109-2110-2111-2112-2113-2114-2115-2116-2117-2118-2119-2120-2121-2122-2123-2124-2125-2126-2127-2128-2129-2130-2131-2132-2133-2134-2135-2136-2137-2138-2139-2140-2141-2142-2143-2144-2145-2146-2147-2148-2149-2150-2151-2152-2153-2154-2155-2156-2157-2158-2159-2160-2161-2162-2163-2164-2165-2166-2167-2168-2169-2170-2171-2172-2173-2174-2175-2176-2177-2178-2179-2180-2181-2182-2183-2184-2185-2186-2187-2188-2189-2190-2191-2192-2193-2194-2195-2196-2197-2198-2199-2200-2201-2202-2203-2204-2205-2206-2207-2208-2209-2210-2211-2212-2213-2214-2215-2216-2217-2218-2219-2220-2221-2222-2223-2224-2225-2226-2227-2228-2229-2230-2231-2232-2233-2234-2235-2236-2237-2238-2239-2240-2241-2242-2243-2244-2245-2246-2247-2248-2249-2250-2251-2252-2253-2254-2255-2256-2257-2258-2259-2260-2261-2262-2263-2264-2265-2266-2267-2268-2269-2270-2271-2272-2273-2274-2275-2276-2277-2278-2279-2280-2281-2282-2283-2284-2285-2286-2287-2288-2289-2290-2291-2292-2293-2294-2295-2296-2297-2298-2299-2300-2301-2302-2303-2304-2305-2306-2307-2308-2309-2310-2311-2312-2313-2314-2315-2316-2317-2318-2319-2320-2321-2322-2323-2324-2325-2326-2327-2328-2329-2330-2331-2332-2333-2334-2335-2336-2337-2338-2339-2340-2341-2342-2343-2344-2345-2346-2347-2348-2349-2350-2351-2352-2353-2354-2355-2356-2357-2358-2359-2360-2361-2362-2363-2364-2365-2366-2367-2368-2369-2370-2371-2372-2373-2374-2375-2376-2377-2378-2379-2380-2381-2382-2383-2384-2385-2386-2387-2388-2389-2390-2391-2392-2393-2394-2395-2396-2397-2398-2399-2400-2401-2402-2403-2404-2405-2406-2407-2408-2409-2410-2411-2412-2413-2414-2415-2416-2417-2418-2419-2420-2421-2422-2423-2424-2425-2426-2427-2428-2429-2430-2431-2432-2433-2434-2435-2436-2437-2438-2439-2440-2441-2442-2443-2444-2445-2446-2447-2448-2449-2450-2451-2452-2453-2454-2455-2456-2457-2458-2459-2460-2461-2462-2463-2464-2465-2466-2467-2468-2469-2470-2471-2472-2473-2474-2475-2476-2477-2478-2479-2480-2481-2482-2483-2484-2485-2486-2487-2488-2489-2490-2491-2492-2493-2494-2495-2496-2497-2498-2499-2500-2501-2502-2503-2504-2505-2506-2507-2508-2509-2510-2511-2512-2513-2514-2515-2516-2517-2518-2519-2520-2521-2522-2523-2524-2525-2526-2527-2528-2529-2530-2531-2532-2533-2534-2535-2536-2537-2538-2539-2540-2541-2542-2543-2544-2545-2546-2547-2548-2549-2550-2551-2552-2553-2554-2555-2556-2557-2558-2559-2560-2561-2562-2563-2564-2565-2566-2567-2568-2569-2570-2571-2572-2573-2574-2575-2576-2577-2578-2579-2580-2581-2582-2583-2584-2585-2586-2587-2588-2589-2590-2591-2592-2593-2594-2595-2596-2597-2598-2599-2600-2601-2602-2603-2604-2605-2606-2607-2608-2609-2610-2611-2612-2613-2614-2615-2616-2617-2618-2619-2620-2621-2622-2623-2624-2625-2626-2627-2628-2629-2630-2631-2632-2633-2634-2635-2636-2637-2638-2639-2640-2641-2642-2643-2644-2645-2646-2647-2648-2649-2650-2651-2652-2653-2654-2655-2656-2657-2658-2659-2660-2661-2662-2663-2664-2665-2666-2667-2668-2669-2670-2671-2672-2673-2674-2675-2676-2677-2678-2679-2680-2681-2682-2683-2684-2685-2686-2687-2688-2689-2690-2691-2692-2693-2694-2695-2696-2697-2698-2699-2700-2701-2702-2703-2704-2705-2706-2707-2708-2709-2710-2711-2712-2713-2714-2715-2716-2717-2718-2719-2720-2721-2722-2723-2724-2725-2726-2727-2728-2729-2730-2731-2732-2733-2734-2735-2736-2737-2738-2739-2740-2741-2742-2743-2744-2745-2746-2747-2748-2749-2750-2751-2752-2753-2754-2755-2756-2757-2758-2759-2760-2761-2762-2763-2764-2765-2766-2767-2768-2769-2770-2771-2772-2773-2774-2775-2776-2777-2778-2779-2780-2781-2782-2783-2784-2785-2786-2787-2788-2789-2790-2791-2792-2793-2794-2795-2796-2797-2798-2799-2800-2801-2802-2803-2804-2805-2806-2807-2808-2809-2810-2811-2812-2813-2814-2815-2816-2817-2818-2819-2820-2821-2822-2823-2824-2825-2826-2827-2828-2829-2830-2831-2832-2833-2834-2835-2836-2837-2838-2839-2840-2841-2842-2843-2844-2845-2846-2847-2848-2849-2850-2851-2852-2853-2854-2855-2856-2857-2858-2859-2860-2861-2862-2863-2864-2865-2866-2867-2868-2869-2870-2871-2872-2873-2874-2875-2876-2877-2878-2879-2880-2881-2882-2883-2884-2885-2886-2887-2888-2889-2890-2891-2892-2893-2894-2895-2896-2897-2898-2899-2900-2901-2902-2903-2904-2905-2906-2907-2908-2909-2910-2911-2912-2913-2914-2915-2916-2917-2918-2919-2920-2921-2922-2923-2924-2925-2926-2927-2928-2929-2930-2931-2932-2933-2934-2935-2936-2937-2938-2939-2940-2941-2942-2943-2944-2945-2946-2947-2948-2949-2950-2951-2952-2953-2954-2955-2956-2957-2958-2959-2960-2961-2962-2963-2964-2965-2966-2967-2968-2969-2970-2971-2972-2973-2974-2975-2976-2977-2978-2979-2980-2981-2982-2983-2984-2985-2986-2987-2988-2989-2990-2991-2992-2993-2994-2995-2996-2997-2998-2999-3000-3001-3002-3003-3004-3005-3006-3007-3008-3009-3010-3011-3012-3013-3014-3015-3016-3017-3018-3019-3020-3021-3022-3023-3024-3025-3026-3027-3028-3029-3030-3031-3032-3033-3034-3035-3036-3037-3038-3039-3040-3041-3042-3043-3044-3045-3046-3047-3048-3049-3050-3051-3052-3053-3054-3055-3056-3057-3058-3059-3060-3061-3062-3063-3064-3065-3066-3067-3068-3069-3070-3071-3072-3073-3074-3075-3076-3077-3078-3079-3080-3081-3082-3083-3084-3085-3086-3087-3088-3089-3090-3091-3092-3093-3094-3095-3096-3097-3098-3099-3100-3101-3102-3103-3104-3105-3106-3107-3108-3109-3110-3111-3112-3113-3114-3115-3116-3117-3118-3119-3120-3121-3122-3123-3124-3125-3126-3127-3128-3129-3130-3131-3132-3133-3134-3135-3136-3137-3138-3139-3140-3141-3142-3143-3144-3145-3146-3147-3148-3149-3150-3151-3152-3153-3154-3155-3156-3157-3158-3159-3160-3161-3162-3163-3164-3165-3166-3167-3168-3169-3170-3171-3172-3173-3174-3175-3176-3177-3178-3179-3180-3181-3182-3183-3184-3185-3186-3187-3188-3189-3190-3191-3192-3193-3194-3195-3196-3197-3198-3199-3200-3201-3202-3203-3204-3205-3206-3207-3208-3209-3210-3211-3212-3213-3214-3215-3216-3217-3218-3219-3220-3221-3222-3223-3224-3225-3226-3227-3228-3229-3230-3231-3232-3233-3234-3235-3236-3237-3238-3239-3240-3241-3242-3243-3244-3245-3246-3247-3248-3249-3250-3251-3252-3253-3254-3255-3256-3257-3258-3259-3260-3261-3262-3263-3264-3265-3266-3267-3268-3269-3270-3271-3272-3273-3274-3275-3276-3277-3278-3279-3280-3281-3282-3283-3284-3285-3286-3287-3288-3289-3290-3291-3292-3293-3294-3295-3296-3297-3298-3299-3300-3301-3302-3303-3304-3305-3306-3307-3308-3309-3310-3311-3312-3313-3314-3315-3316-3317-3318-3319-3320-3321-3322-3323-3324-3325-3326-3327-3328-3329-3330-3331-3332-3333-3334-3335-3336-3337-3338-3339-3340-3341-3342-3343-3344-3345-3346-3347-3348-3349-3350-3351-3352-3353-3354-3355-3356-3357-3358-3359-3360-3361-3362-3363-3364-3365-3366-3367-3368-3369-3370-3371-3372-3373-3374-3375-3376-3377-3378-3379-3380-3381-3382-3383-3384-3385-3386-3387-3388-3389-3390-3391-3392-3393-3394-3395-3396-3397-3398-3399-3400-3401-3402-3403-3404-3405-3406-3407-3408-3409-3410-3411-3412-3413-3414-3415-3416-3417-3418-3419-3420-3421-3422-3423-3424-3425-3426-3427-3428-3429-3430-3431-3432-3433-3434-3435-3436-3437-3438-3439-3440-3441-3442-3443-3444-3445-3446-3447-3448-3449-3450-3451-3452-3453-3454-3455-3456-3457-3458-3459-3460-3461-3462-3463-3464-3465-3466-3467-3468-3469-3470-3471-3472-3473-3474-3475-3476-3477-3478-3479-3480-3481-3482-3483-3484-3485-3486-3487-3488-3489-3490-3491-3492-3493-3494-3495-3496-3497-3498-3499-3500-3501-3502-3503-3504-3505-3506-3507-3508-3509-3510-3511-3512-3513-3514-3515-3516-3517-3518-3519-3520-3521-3522-3523-3524-3525-3526-3527-3528-3529-3530-3531-3532-3533-3534-3535-3536-3537-3538-3539-3540-3541-3542-3543-3544-3545-3546-3547-3548-3549-3550-3551-3552-3553-3554-3555-3556-3557-3558-3559-3560-3561-3562-3563-3564-3565-3566-3567-3568-3569-3570-3571-3572-3573-3574-3575-3576-3577-3578-3579-3580-3581-3582-3583-3584-3585-3586-3587-3588-3589-3590-3591-3592-3593-3594-3595-3596-3597-3598-3599-3600-3601-3602-3603-3604-3605-3606-3607-3608-3609-3610-3611-3612-3613-3614-3615-3616-3617-3618-3619-3620-3621-3622-3623-3624-3625-3626-3627-3628-3629-3630-3631-3632-3633-3634-3635-3636-3637-3638-3639-3640-3641-3642-3643-3644-3645-3646-3647-3648-3649-3650-3651-3652-3653-3654-3655-3656-3657-3658-3659-3660-3661-3662-3663-3664-3665-3666-3667-3668-3669-3670-3671-3672-3673-3674-3675-3676-3677-3678-3679-3680-3681-3682-3683-3684-3685-3686-3687-3688-3689-3690-3691-3692-3693-3694-3695-3696-3697-3698-3699-3700-3701-3702-3703-3704-3705-3706-3707-3708-3709-3710-3711-3712-3713-3714-3715-3716-3717-3718-3719-3720-3721-3722-3723-3724-3725-3726-3727-3728-3729-3730-3731-3732-3733-3734-3735-3736-3737-3738-3739-3740-3741-3742-3743-3744-3745-3746-3747-3748-3749-3750-3751-3752-3753-3754-3755-3756-3757-3758-3759-3760-3761-3762-3763-3764-3765-3766-3767-3768-3769-3770-3771-3772-3773-3774-3775-3776-3777-3778-3779-3780-3781-3782-3783-3784-3785-3786-3787-3788-3789-3790-3791-3792-3793-3794-3795-3796-3797-3798-3799-3800-3801-3802-3803-3804-3805-3806-3807-3808-3809-3810-3811-3812-3813-3814-3815-3816-3817-3818-3819-3820-3821-3822-3823-3824-3825-3826-3827-3828-3829-3830-3831-3832-3833-3834-3835-3836-3837-3838-3839-3840-3841-3842-3843-3844-3845-3846-3847-3848-3849-3850-3851-3852-3853-3854-3855-3856-3857-3858-3859-3860-3861-3862-3863-3864-3865-3866-3867-3868-3869-3870-3871-3872-3873-3874-3875-3876-3877-3878-3879-3880-3881-3882-3883-3884-3885-3886-3887-3888-3889-3890-3891-3892-3893-3894-3895-3896-3897-3898-3899-3900-3901-3902-3903-3904-3905-3906-3907-3908-3909-3910-3911-3912-3913-3914-3915-3916-3917-3918-3919-3920-3921-3922-3923-3924-3925-3926-3927-3928-3929-3930-3931-3932-3933-3934-3935-3936-3937-3938-3939-3940-3941-3942-3943-3944-3945-3946-3947-3948-3949-3950-3951-3952-3953-3954-3955-3956-3957-3958-3959-3960-3961-3962-3963-3964-3965-3966-3967-3968-3969-3970-3971-3972-3973-3974-3975-3976-3977-3978-3979-3980-3981-3982-3983-3984-3985-3986-3987-3988-3989-3990-3991-3992-3993-3994-3995-3996-3997-3998-3999-4000-4001-4002-4003-4004-4005-4006-4007-4008-4009-4010-4011-4012-4013-4014-4015-4016-4017-4018-4019-4020-4021-4022-4023-4024-4025-4026-4027-4028-4029-4030-4031-4032-4033-4034-4035-4036-4037-

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86347

C86347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *123 N. Ross* ST. *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Elizabeth Albert*(Residence in Baltimore: No. *123 N. Ross* St.; *30* yrs., *mos.* *ds.*)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Don't know*, 1838

(Month)

(Day)

(Year)

7-AGE, *77* yrs., *mos.* *ds.*If LESS than 1 day, *hrs.* or *min.*?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Germany*

PARENTS.

10-NAME OF FATHER, *unknown*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Chas Albert*(Address) *123 N. Ross St.*

15-

Filed JUN 30 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 29, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 4* 1915, to *June 29* 1915, that I saw her alive on *June 28* 1915, and that death occurred, on the date stated above, at *3:00* m.

The CAUSE OF DEATH* was as follows:

Bright Kidney
Septic(Duration) *2* yrs., *mos.* *ds.*CONTRIBUTORY (Secondary) *Branchitis*(Duration) *1* yrs., *mos.* *ds.*(Signed) *G. O. DeLoach* M. D.
6/29, 1915. (Address) *2601 E. Pratt St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *30* yrs., *mos.* *ds.* In the State *30* yrs., *mos.* *ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer*DATE OF BURIAL, *7/2*, 191520-UNDERTAKER, *William Corp*ADDRESS, *502 E North*

ADDRESS

C86349

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86349

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Home & Inf.* ST. *6* WARD)-FULL NAME *Samuel King*Residence in Baltimore: No. *Spartanburg St. 61*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: — yrs., — mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Married*

6-DATE OF BIRTH.

May 6

(Month)

(Day)

1886

(Year)

7-AGE.

29

yrs.

1

mos.

23

ds.

If LESS than 1 day.

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Travelling Salesman*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country). *Balto*

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER

(State or Country). *Balto*

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country). *Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. S. Hechtman*(Address) *Marlborough apt.*

15-

JUN 30 1915

HARRY O. A. LEWIS,

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June

(Month)

29, 1915

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 22 1915 to *June 29 1915*that I saw him alive on *June 29 1915*and that death occurred, on the date stated above, at *8:30 P.m.*

The CAUSE OF DEATH* was as follows:

Typhoid Fever(Duration) *25* mos. *25* ds.CONTRIBUTORY (Secondary) *Typhoid Pneumonia*(Duration) *1* mos. *1* ds.(Signed) *J. Daugherty* M. D.*June 29 1915* (Address) *Church Home & Inf.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *7* mos. *7* ds. In the State yrs. *7* mos. *7* ds.Where was disease contracted, if not at place of death? *Unknown*Former or usual residence *Spartanburg S. C.*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Linden Park**July 1, 1915*

20-UNDERTAKER

ADDRESS

*J. Ahrens & Co.**1611 Madison Ave.*

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1011 S. Potomac* ST.; WA(1D)

FULL NAME

Child of John G. & Eva Beynon(Residence in Baltimore: No. *1011 S. Potomac*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED, *Baby*
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

June 28, 1915
(Month) (Day) (Year)

7-AGE.

2 yrs. mos. ds. If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).*Maryland*

10-NAME OF FATHER.

*John G. Beynon*11-BIRTHPLACE OF FATHER
(State or Country).*Maryland*

12-MAIDEN NAME OF MOTHER

*Eva Ritterbusch*13-BIRTHPLACE OF MOTHER
(State or Country).*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John G. Beynon*(Address) *1011 S. Potomac St.*15-
JUN 30 1915

Filed..... 191..... HARRY O. ANDERSON

Marial Form 10-1015

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 30, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from
June 28, 1915 to *June 30, 1915*,
that I saw her alive on *June 28, 1915*,
and that death occurred, on the date stated above, at *6 A* m.
The CAUSE OF DEATH* was as follows:*6 Month Foetus*

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. B. Vetter* M. D.*June 30, 1915*. (Address) *3035 Odonnell*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Carmel Cem.

DATE OF BURIAL.

June 30, 1915

20-UNDERTAKER

Girkler & Girkler

ADDRESS

1737 E. Egan St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *8 Rose Place* ST. *11* WARD)2-FULL NAME *Eddie I. Johnson*(Residence in Baltimore: No. *8 Rose Place* St. *47* yrs. — mos. — ds.)REGISTERED NO. C *79*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*4-COLOR OR RACE, *Colored*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, *June* 1868

(Month)

(Day)

(Year)

7-AGE, *47*

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Coachman*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balto*

PARENTS.

10-NAME OF FATHER *Littleton E. Johnson*11-BIRTHPLACE OF FATHER (State or Country), *MD*12-MAIDEN NAME OF MOTHER *Annie E. Hughes*13-BIRTHPLACE OF MOTHER (State or Country), *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Annie E. Johnson*(Address) *709 George St*

15-

Filed

JUN 30 1915

HARRY O. ANDREWS,

Special Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *June* 28, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *June 1* - 1915, to *June 27* 1915, that I saw him alive on *June 26* 1915, and that death occurred, on the date stated above, at *3:30* m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency(Duration) *2* yrs. — mos. — ds.CONTRIBUTORY (Secondary) *Exhaustion*(Duration) *14* yrs. — mos. — ds.(Signed) *J. J. Hughes* M. D.*June 28* 1915 (Address) *1413 - 2nd St. Balto*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt. Auburn*DATE OF BURIAL, *6/30*, 191520-UNDERTAKER *Sam'l. T. Thawley*ADDRESS *5800 Biddle*

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86352

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Brentwood Avenue ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laurence Ward

(Residence in Baltimore: No. 1107 Brentwood Avenue St.; 70 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

March 1st, 1882
(Month) (Day) (Year)

7-AGE,

43 yrs. 3 mos. 28 ds.

If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Retired.
(b) General nature of industry, business, or establishment in which employed (or employer). Music teacher

9-BIRTHPLACE, (State or Country),

Ireland.

PARENTS.

10-NAME OF FATHER,

James Ward.

11-BIRTHPLACE OF FATHER (State or Country),

Ireland.

12-MAIDEN NAME OF MOTHER

Margaret Genet

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Eugene P. Vaughn

(Address)... 1107 Brentwood Avenue.

15-

JUN 30 1915 HARRY O. ANDERSON, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 8, 1915, to June 29, 1915, that I saw him alive on June 28, 1915, and that death occurred, on the date stated above, at 122 m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis + apoplexy

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic nephritis

(Signed) James M. Henderson M. D.

June 29, 1915. (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery.

DATE OF BURIAL,

July 1, 1915.

20-UNDERTAKER

Chas. Brown, Son

ADDRESS

118 W. Mt. Royal

Certificate of Death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

16-15- Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *3044* *Boston* ST. *1* WARD)

FULL NAME *John Slawik*

(Residence in Baltimore: No. *3044* *Boston* St.: *1* yrs. *1* mos. / *1* da.)

REGISTERED No. C. *152*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*

4-COLOR OR RACE, *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)

6-DATE OF BIRTH, *June 28th, 1915*

(Month)

(Day)

(Year)

7-AGE, *1* yrs. *1* mos. *1* da.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE,
(State or Country), *Baltimore*

10-NAME OF FATHER, *John Slawik*

11-BIRTHPLACE OF FATHER
(State or Country), *Russia*

12-MAIDEN NAME OF MOTHER, *Mary Skymakow*

13-BIRTHPLACE OF MOTHER
(State or Country), *Austria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Slawik*

(Address) *3044 Boston St.*

15-

JUN 30 1915

HARRY O. ANDREWS,

101 *Official Permit Clerk*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 29th, 1915*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*

(Inquest, au-

topsy or inquiry) and that said deceased came to *his* death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Atalaxia Nervatorum

(Duration) *1* yrs. *1* mos. *1* da.

CONTRIBUTORY
(Secondary)

(Duration) *1* yrs. *1* mos. *1* da.

(Signed) *D. W. Jones* M. D.

(Coroner)

June 30, 1915 (Address) *3116 Osmond St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the

of death *1* yrs. *1* mos. *1* da. State *1* yrs. *1* mos. *1* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Stanislaus Cem.

June 30, 1915

20-UNDERTAKER

ADDRESS

Stephen J. Zielkowski

10192 Kenwood Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C86351 152 C86351
1-PLACE OF DEATH
CITY OF BALTIMORE (No. 3044 Boston ST. 1 WARD)
2-FULL NAME Adam Slowik
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
Residence in Baltimore: No. 3044 Boston St. yrs. mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male	4-COLOR OR RACE, White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)
6-DATE OF BIRTH, June 28, 1915 (Month) (Day) (Year)		
7-AGE, — yrs. — mos. / ds. If LESS than 1 day, ...hrs. or...min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work... None (b) General nature of industry, business, or establishment in which employed (or employer)...		
9-BIRTHPLACE, (State or Country), Baltimore		
PARENTS.	10-NAME OF FATHER, John Slowik	
	11-BIRTHPLACE OF FATHER (State or Country), Russia	
	12-MAIDEN NAME OF MOTHER, Mary Szymankov	
	13-BIRTHPLACE OF MOTHER (State or Country), Austria	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Slowik
(Address) 3044 Boston St.

15 JUN 30 1915

Filed..... 191... HARRY O. ANDREWS
Burial Permit Officer

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 29, 1915
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said... (Inquest, au-
topsy or inquiry.) and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Atalantia Nervorum

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. W. Jones M. D.

(Coroner.)

June 29, 1915 (Address) 116 O'Donnell St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?...

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Stanislaus Cem.

June 30, 1915

20-UNDERTAKER

ADDRESS

Stephen J. Zalkowski 10192 Kenwood Ave

C86355

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86355

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3112 Auchentoroly Terrace ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Duffey(Residence in Baltimore: No. 3112 Auchentoroly Terrace St.; 56 yrs., 6 mos., 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male4-COLOR OR RACE White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH December 20, 1858

(Month)

(Day)

(Year)

7-AGE 56 yrs., 6 mos., 8 ds.

IF LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....Print Lithographer
(b) General nature of industry, business, or establishment in which employed (or employer).....Full Lithographer9-BIRTHPLACE, (State or Country), Maryland10-NAME OF FATHER, John J. Duffey11-BIRTHPLACE OF FATHER (State or Country), Ireland12-MAIDEN NAME OF MOTHER Margaret O'Brien13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Duffey(Address) 1618 Guilford St.15-JUN 30 1915

Filed....., 191.....

HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH June 28, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 18, 1915, to June 28, 1915, that I saw him alive on June 27, 1915, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy
with acute dilatation
(3 wks.) (Duration).....yrs.....mos.....ds.CONTRIBUTORY (Secondary) Embolic

(Duration).....yrs.....mos.....ds.

(Signed) J. T. Moore M. D.June 7, 1915 (Address) 1042 E. Edwards St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral CemeteryJuly 1, 1915

20-UNDERTAKER

ADDRESS

Edward J. Howenlo108 N. North Ave.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *Mercy Hospital* ST. *14* WARD)

2-FULL NAME

(Residence in Baltimore: No. *2029 Division St.* St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Black

5-SINGLE,

MARRIED

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

Mar 28, 1896
(Month) (Day) (Year)

7-AGE.

19 yrs. *2* mos. *1* ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Bill Boy
Phoenix Club

9-BIRTHPLACE,

(State or Country).

MD

10-NAME OF FATHER.

William Parkman

11-BIRTHPLACE OF FATHER

(State or Country).

Va.

12-MAIDEN NAME OF MOTHER

Hannie ?

13-BIRTHPLACE OF MOTHER

(State or Country).

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

George Henry Hoff
Christ St.

15-

JUN 30 1915

Filed.

ROBERT J. KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 29, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *June 28, 1915* to *June 29, 1915*that I saw him alive on *June 29, 1915* and that death occurred, on the date stated above, at *2:40 P.* m.

The CAUSE OF DEATH* was as follows:

*Pericuteal Appendicitis**What* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Enteritis (Duration) yrs. mos. ds.(Signed) *Edward J. Sweet* M. D.*June 29, 1915* (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *2029 Division St.*Former or usual residence *2029 Division St.*

19-PLACE OF BURIAL OR REMOVAL.

Gray Creek Co. Va.

DATE OF BURIAL.

July 1, 1915

20-UNDERTAKER

George H. Holland

ADDRESS

377
Robert St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

OF BALTIMORE: (No. *Hebrew Hospital* ST. *3* WARD)2-FULL NAME *Rachel Weintraub (Weintraub)*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

(Residence in Baltimore: No. *122 Lloyd* St.; yrs. *10* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *white* 5-SINGLE *single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH *July 30* 1914
(Month) (Day) (Year)7-AGE *11* yrs. *11* mos. *11* ds. or min.?9-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*None*8-BIRTHPLACE
(State or country)*Baltimore Md.*

PARENTS

10-NAME OF FATHER *Louis Weintraub*11-BIRTHPLACE OF FATHER
(State or country)*Russia*

12-MAIDEN NAME OF MOTHER

*Paul Saltzky*13-BIRTHPLACE OF MOTHER
(State or country)*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Louis Weintraub*(Address) *122 Lloyd St*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 30* 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 21*, 1915, to *June 30* 1915, that I saw her alive on *June 30* 1915, and that death occurred, on the date stated above, at *145* p.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) yrs. *10* mos. ds.Contributory
(SECONDARY)(Duration) yrs. *10* mos. ds.(Signed) *M. B. Levin* M. D.
June 30 1915 [Address] *Hebrew Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. *10* mos. *10* ds. State yrs. *10* mos. *10* ds.Where was disease contracted, *122 Lloyd St*
If not at place of death?Former or usual residence *122 Lloyd St*

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hebrew Mt Carmel June 30 1915

20-UNDERTAKER

ADDRESS *1107 E**S. Lennson & Bro Baltimore*

JUN 30 1915

ROBERT KRAUTER

Bureau of Health Officer

REGISTRAR

N.B.—Every claim for indemnity against the City of Baltimore requires a statement of OCCUPATION is very important. See instructions on back of certificate.

C86358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

61 C86358

1-PLACE OF DEATH *John Hopkins Hospital*

REGISTERED NO. C

CITY OF BALTIMORE; (No. *8*)ST.; *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary Powell*Residence in Baltimore: No. *2403 Mace St.*

St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Black*5-SINGLE, *single*MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Feb. 20, 1915

(Month)

(Day)

1915

(Year)

7-AGE,

4 yrs. 9 mos. 9 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*child*

9-BIRTHPLACE,

(State or Country).

Maryland

10-NAME OF FATHER,

Alfred Powell

11-BIRTHPLACE OF FATHER

(State or Country).

Maryland

12-MAIDEN NAME OF MOTHER

Catherine Matthews

13-BIRTHPLACE OF MOTHER

(State or Country).

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Grace Bone

(Address).....

John Hopkins Hospital

15-JUN 30 1915

ROBERT KRAUTER,

Filed..... 1915

Bureau of Vital Records

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 29

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 28

1915

to

June 29

1915

that I saw her alive on *June 29*

1915

and that death occurred, on the date stated above, at *2:50 p.m.*

The CAUSE OF DEATH* was as follows:

Chorea meningitis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... *G. A. Batten*..... M. D.*June 29, 1915* (Address) *John Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death? *x*Former or usual residence *2403 Mace St.*

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

July 1, 1915

20-UNDERTAKER

Felix B. Pye

ADDRESS

1030 Myrtle St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *1535 Barclay St.* ST.: *12* WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

FULL NAME *Henry Calaborn Piusley Jr.*(Residence in Baltimore: No. *1535 Barclay St.* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

August 10th, 1906
(Month) (Day) (Year)

7-AGE,

8 yrs. 10 mos. 19 ds.

IT LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Mo.

10-NAME OF FATHER,

Henry Piusley

11-BIRTHPLACE OF FATHER (State or Country),

Mo.

12-MAIDEN NAME OF MOTHER

Elizabeth Brigger

13-BIRTHPLACE OF MOTHER (State or Country),

Mo.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Piusley*(Address) *1535 Barclay St.*

15-

JUN 30 1915

ROBERT KRAUTER

MAY 12 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 29th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 17th, 1915, to June 29th, 1915*that I saw him alive on *June 29th, 1915*and that death occurred, on the date stated above, at *6 PM*

The CAUSE OF DEATH* was as follows:

Robert - Cerebral(Duration) yrs. mos. ds. *12 ds.*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Geo. W. Shurgavoy, M.D.**June 29th, 1915* (Address) *2537 Thacker Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

July 1st, 1915

20-UNDERTAKER

Felix B. Pye

ADDRESS

102 E. ...

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *417 Courtland* ST. *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *417 Courtland* St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

April 19, 1853
(Month) (Day) (Year)

7-AGE,

67 yrs. 2 mos. 6 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Museum

9-BIRTHPLACE,

(State or Country),

Mayland

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

John J. Graf
417 Courtland
*WUN 3.0 1915**ROBERT KRAUTH**WUN 3.0 1915*
Registraz.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 30, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 25 1915, to *June 30 1915*,that I saw her alive on *June 30 1915*and that death occurred, on the date stated above, at *2501* m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) yrs. mos. ds. *16*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. *6*(Signed) *Russell M. D.**1915* (Address) *5028 North*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore *July 2, 1915*

20-UNDERTAKER

ADDRESS

William Cook *5028 North*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *J. H. Hospital* ST.; *11* WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1206 N. Charles St.* St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, *married*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

*Nov**24**1892*

(Month)

(Day)

(Year)

7-AGE.

*42**7**mos.**6**ds.*

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

stock holder

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Thomas B. Harrison

11-BIRTHPLACE OF FATHER (State or Country),

Ind.

12-MAIDEN NAME OF MOTHER

Mary B. Williams

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *E. M. Rose*(Address) *J. H. Hospital*

15-

JUN 30 1915

Filed

DEPT. OF HEALTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*June**30**1915*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 22 1915, to *June 30*, 1915,that I saw him alive on *June 30*, 1915,and that death occurred, on the date stated above, at *5:02 P.* m.

The CAUSE OF DEATH* was as follows:

Apoplexy

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. B. End* M. D.*June 30*, 1915. (Address) *J. H. Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State *42* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1206 N. Charles St.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

*Thomas Harrison Jones**7-3-1915*

20-UNDERTAKER

ADDRESS

May W. Jenkins & Sons Co. McCulloch & Crebhard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH
CITY OF BALTIMORE (No. 813 N Gilman ST. 16 WARD)
FULL NAME Elizabeth Boyer
(Residence in Baltimore: No. 813 N Gilman St. 40 yrs. — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

1. SEX Female
2. COLOR OR RACE White
3. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)
4. DATE OF BIRTH Not known
(Month) (Day) (Year)
5. AGE 87 yrs. — mos. — ds. or — min.?
If LESS than 1 day, — hrs.
6. OCCUPATION None
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
7. BIRTHPLACE (State or country) Federick Co Md
8. NAME OF FATHER W C Brandenburg
9. BIRTHPLACE OF FATHER (State or country) Md
10. MAIDEN NAME OF MOTHER Not known
11. BIRTHPLACE OF MOTHER (State or country) Md

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

JUN 30 1915

REGENT, KRAUTER,
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1915, to June 28, 1915, that I saw her alive on June 27, 1915, and that death occurred, on the date stated above, at 8 P. M. The CAUSE OF DEATH* was as follows:

Aproplexy (second attack)

(Duration) a few hours yrs. — mos. — ds.

Contributory (SECONDARY)

Infirmities of old age

(Duration) yrs. — mos. — ds.

(Signed),

John Ford M. D.
June 29, 1915 (Address) 630 N Gilman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Marys Md
20. UNDERTAKER Geo A Gertig

July 1, 1915
ADDRESS Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *917 Boyd St.* ST.; *18* WARD)FULL NAME *Florence Gray*(Residence in Baltimore: No. *917 Boyd St.* St.; *2 yrs., 11 mos. 4 ds.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *July 24, 1893*7-AGE, *2 yrs., 11 mos. 4 ds.*

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Washer*(b) General nature of industry, business, or establishment in which employed (or employer), *Washing Machine*9-BIRTHPLACE, (State or Country), *City*10-NAME OF FATHER, *William Gray*11-BIRTHPLACE OF FATHER (State or Country), *City*12-MAIDEN NAME OF MOTHER, *Nancy Gray*13-BIRTHPLACE OF MOTHER (State or Country), *City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Nancy Gray*(Address) *917 Boyd St.*

15- JUL 1 - 1915

HARRY O. ANDREWS,

Filed....., 191... *Marial Permitt Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 28, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 15* 1915, to *June 28* 1915, that I saw her alive on *June 28* 1915, and that death occurred, on the date stated above, at *11:30 P.M.*

The CAUSE OF DEATH* was as follows:

Dilatation of heart(Duration) *7 hours*

yrs.

mos.

ds.

CONTRIBUTORY... *Endocarditis*

(Secondary)

(Duration) *5 mos. 13 ds.*

yrs.

mos.

ds.

(Signed) *Chester Riland*

M. D.

6-29-, 1915 (Address) *2532 Edmondson Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *North Anson*DATE OF BURIAL, *July 1, 1915*20-UNDERTAKER, *John H. H. & Son*ADDRESS, *901 Bolling*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1030 N. Dallas St.* ST. *7* WARD)

REGISTERED NO. C

2-FULL NAME

Ellen Frances Hope

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1030 N. Dallas St.* St.: — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, *Widow*,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

September 8th, 1835
(Month) (Day) (Year)

7-AGE,

79 yrs. *9* mos. *31* ds.If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....*None*9-BIRTHPLACE,
(State or Country),*Ind.*10-NAME OF
FATHER,*Thos. Martin*11-BIRTHPLACE
OF FATHER
(State or Country),*Ind.*12-MAIDEN NAME
OF MOTHER*Mary Hockersmith*13-BIRTHPLACE
OF MOTHER
(State or Country),*Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas. W. Cope

(Address)

1409 Baltimore St.

15-

Filed.....

*JUL 1 - 1915**HARRY C. ANDERSON**Barlow Park, Md.*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 29th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 15th 1915, to *June 29th* 1915,that I saw ~~her~~ alive on *June 29th* 1915,and that death occurred, on the date stated above, at *4:40 P.M.*

The CAUSE OF DEATH* was as follows:

Pyelitis and
Cystitis.(Duration)..... yrs. *3* mos. ds.CONTRIBUTORY.
(Secondary)*Heretofore Coronary*(Duration)..... yrs. *?* mos. ds.(Signed) *Geo. H. Montgomery, M.D.**June 29th*, 1915. (Address) *2537 Trammell St. Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

New Catholic

DATE OF BURIAL,

July 2nd, 1915.

20-UNDERTAKER

Rich Turner

ADDRESS

14424 Bway

important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86365

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86365

CERTIFICATE OF DEATH

151

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

2622 E. Hoffman St.

WARD)

2-FULL NAME

Karl A Kaufmann Jr

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No.

2622 E. Hoffman

Sr. X yrs. X mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

16-DATE OF DEATH

JUNE 30, 1915
(Month) (Day) (Year)

6-DATE OF BIRTH

JUNE 19, 1915
(Month) (Day) (Year)

7-AGE

X yrs. X mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

X

9-BIRTHPLACE (State or country)

Baltimore Md

10-NAME OF FATHER

Alfred W Kaufmann

11-BIRTHPLACE OF FATHER (State or country)

Germany

12-MAIDEN NAME OF MOTHER

Elizabeth Baeris

13-BIRTHPLACE OF MOTHER (State or country)

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Karl A Kaufmann Jr
2622 E Hoffman St

17. I HEREBY CERTIFY, That I attended deceased from JUNE 19, 1915, to JUNE 30, 1915, that I saw him alive on JUNE 29, 1915, and that death occurred, on the date stated above, at 7 A.M. The CAUSE OF DEATH* was as follows:

Congenital Heart weakness

Contributory (SECONDARY) Icterus neonatorum
(Duration) X yrs. X mos. 11 ds.
(Signed) O. H. Diker M. D.
JUNE 30, 1915 (Address) 928 E North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore County

July 1, 1915

20-UNDERTAKER

ADDRESS

Robert Turner 14429 Bway

15 JUL 1 - 1915

HARRY O. ANDREWS,

Filed

Serial Permit Clerk

REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86366

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86366

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *St Josephs Hosp* ST. *2* WARD)

FULL NAME *William T Holloman*

(Residence in Baltimore: No. *202 S Wolf*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, *Male*

4-COLOR OR RACE, *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *July 5th, 1868*

7-AGE, *46* yrs. *11* mos. *22* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Sailor*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Pa*

10-NAME OF FATHER, *Thomas J Holloman*

11-BIRTHPLACE OF FATHER (State or Country), *Pa*

12-MAIDEN NAME OF MOTHER *Catherine Greenstead*

13-BIRTHPLACE OF MOTHER (State or Country), *Pa*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hattie Holloman*

(Address) *202 S Wolf St*

15-JUL 1 - 1915

Filed, 191

HARRY O. ANDREWS,
Marial Permit Clerk,
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 27th, 1915*

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull by being struck by a wagon shaft in the hands of George H. Biles June 21st 1915

(Duration) yrs. mos. ds. *N.S. Phila Rd. east of City Limits*
CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. (Signed) *Olysh J. Russell* M. D. (Coroner.)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Trinity Cemetery*

DATE OF BURIAL, *July 1, 1915*

20-NAME OF ADDRESS

Christian Miller 2334 Jefferson St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 19 WARD)

2-FULL NAME

(Residence in Baltimore: No.

Str. 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married.
6-DATE OF BIRTH March 7, 1885 (Month) (Day) (Year)		
7-AGE 30 yrs. 3 mos. 23 ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Draftsman		
9-BIRTHPLACE (State or country) Maryland		
PARENTS	10-NAME OF FATHER James F. Daniel	
	11-BIRTHPLACE OF FATHER (State or country) Md.	
	12-MAIDEN NAME OF MOTHER Mary C. Ueborn	
	13-BIRTHPLACE OF MOTHER (State or country) Md.	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15
JUL 1 - 1915
Filed

HARRY O. ANDREWS,
Marial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 30, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from

May 30, 1915, to, June 30, 1915

that I saw him alive on June 30, 1915

and that death occurred, on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
tuberculous abscess of rectum
(Duration) don't know mos. ds.

Contributory (SECONDARY) Pulmonary hemorrhage
(Duration) 4 yrs. mos. 4 ds.

(Signed) J. H. Early M. D.

June 30, 1915 (Address) 3714 Prentiss

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Cemetery July 2, 1915

20-UNDERTAKER

Joseph B. Cook 1003 W. Baltimore St.

C86368

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86368

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3302, Beech Ave. 13

ST.; WARD)

REGISTERED NO. C

2-FULL NAME

Milton Campbell

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No.

3302, Beech Ave

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH

June

(Month)

30

(Day)

1915

(Year)

7-AGE,

If LESS than 1 day,

2 hrs. or... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Md (city)

10-NAME OF FATHER,

Norman Campbell

11-BIRTHPLACE OF FATHER

(State or Country),

Penn

12-MAIDEN NAME OF MOTHER

Gretna Deardoff

13-BIRTHPLACE OF MOTHER

(State or Country),

Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Father

(Address)

3302 Beech Ave

15-

JUL 1 1915

HARRY O. ANDREWS,

Baptist Permit Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June

(Month)

30, 1915

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 30 1915, to June 30 1915,

that I saw him alive on June 30 1915, and that death occurred, on the date stated above, at 1-30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
Congenital Deformity

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. Fair

June 30 1915. (Address) 12 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Marys

July 1, 1915

20-UNDERTAKER

ADDRESS

J. J. Marshall 3539 Hill Rd

important. See instructions on back of certificate.

C86369

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86369

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *S. W. Cor Fulton Ave and Franklin St.* *20* WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

2. FULL NAME

George F. Wise

(Residence in Baltimore: No.

Home for the Aged of the M. E. Church. St.: 50 yrs., mon. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Widowed

6-DATE OF BIRTH,

June 10, 1890
(Month) (Day) (Year)

7-AGE,

85 yrs. 0 mos. 19 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Geo. F. Wise

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Margaret Hacker

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss E. Rebekah Menshaw*(Address) *Supt. Methodist Home for the Aged*

15-

*JUL 1 - 1915**HARRY O. ANDREWS,*Filed..... 191.. *Burial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 29, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 20* 191*5*, to *June 29* 191*5*, that I saw him alive on *June 28* 191*5*, and that death occurred, on the date stated above, at *530* m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic(Duration) *4* yrs. *1* mon. *1* ds.

CONTRIBUTORY (Secondary)

Pericarditis(Duration) *9* yrs. *9* mon. *1* ds.(Signed) *Geo. C. Shannon* M. D.*June 30*, 191*5* (Address) *700 Fulton Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *5* yrs. *8* mos. *1* ds. In the *50* yrs. *1* mon. *1* ds.Where was disease contracted, if not at place of death? *Home for the Aged of the M. E. Church*Former or usual residence *Home for the Aged of the M. E. Church*

19-PLACE OF BURIAL OR REMOVAL,

Landon Park Cemetery

DATE OF BURIAL,

July 1, 1915

20-UNDERTAKER

George J. Smith

ADDRESS,

1006 1/2 Fayette St

important. See instructions on back of certificate.

STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 N. Register ST. 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1701 N. Register St. 24 yrs. 9 mos. 9 ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME; instead of street and number and SN out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
DIVORCED

6-DATE OF BIRTH

7-AGE

IF LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

15-JUL 1 1915

HARRY O. ANDREWS,
Serial Permit Clerk,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on June 28 1915, and that death occurred on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

(Pulmonary & Handular)
Tuberculosis

Contributory
(SECONDARY)

(Signed)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

169

C86371

PLACE OF DEATH
CITY OF BALTIMORE (No. *Chesapeake Beach, Md.* ST.: *9*)
FULL NAME *Joseph J. O'Connor*
(Residence in Baltimore: No. *1322 N. Euseb*)

REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>Single</i> (Write the word.)
6-DATE OF BIRTH, <i>March 17th, 1878</i> (Month) (Day) (Year)		
7-AGE, <i>37</i> yrs. <i>3</i> mos. <i>12</i> ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <i>Foreman</i> (b) General nature of industry, business, or establishment in which employed (or employer), <i>City Subway</i>		
9-BIRTHPLACE, (State or Country), <i>Baltimore</i>		
PARENTS.	10-NAME OF FATHER, <i>Michael J. O'Connor</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Ireland</i>	
	12-MAIDEN NAME OF MOTHER <i>Dorothy A. Adams</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Baltimore</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Matthew O'Connor*
(Address) *1322 N. Euseb St.*

15- JUL 1 - 1915

Filed..... 101.....
HARRY O. ANDREWS,
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,
June 29th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental Drowning
(Duration) yrs. mos. ds.
CONTRIBUTORY *Probably Acute Indigestion* (Secondary)
(Duration) yrs. mos. ds.
(Signed) *W. Jones* M. D. (Coroner.)
June 30, 1915 (Address) *3116 Wilkes St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.... yrs. mos. ds. State.... yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, <i>New Cathedral</i>	DATE OF BURIAL, <i>July 1, 1915</i>
20-UNDERTAKER <i>Wm. W. Sawin</i>	ADDRESS <i>1624 Mt. Royal Ave</i>

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

086372

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

126 086372

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 220 E. 22nd ST. 12 WARD)
2-FULL NAME Joseph L. Wheeler
(Residence in Baltimore: No. 220 E. 22nd St.; 70 yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE Widower
6-DATE OF BIRTH April 6, 1830
7-AGE 85 yrs. 2 mos. 24 ds. or min.?
8-OCCUPATION Retired Merchant

9-BIRTHPLACE (State or country) Anne Arundel Co

10-NAME OF FATHER Cpt Baruch Wheeler
11-BIRTHPLACE OF FATHER (State or country) Md
12-MAIDEN NAME OF MOTHER Annie G. Brown
13-BIRTHPLACE OF MOTHER (State or country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John M. Wheeler
(Address) 220 E. 22nd

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 30, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 11, 1915, to June 30, 1915, that I saw him alive on June 30, 1915, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Prostatitis

Contributory (SECONDARY)

do not know
1. oxemia (U)
(Duration) yrs. 10 mos. — ds.

(Signed) Geo. W. De Hoff M. D.
July 1, 1915 [Address] 2020 N. Charles

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. — mos. — ds. State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Greenmount Cem July 3, 1915

20-UNDERTAKER ADDRESS

Natty W. Cohen W. Northon

18- JUL 1 - 1915: HARRY O. ANDREWS, Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86373

CERTIFICATE OF DEATH.

120 C86373
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 Eastern Ave. ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Kappler(Residence in Baltimore: No. 1525 Eastern Ave. St.; 40 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
(Write the word.)6-DATE OF BIRTH, December 20, 1860
(Month) (Day) (Year)7-AGE, 54 yrs., 6 mos., 9 ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House Painter
(b) General nature of industry, business, or establishment in which employed (or employer). at saw mill9-BIRTHPLACE, (State or Country), Va.PARENTS.
10-NAME OF FATHER, Michael Kappler
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Fridencka
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Catherine Kappler(Address) 1525 Eastern Ave.15-JUL 1 - 1915, HARRY O. ALLEN
Filed 181, Marial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 29, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 18, 1915, to June 29, 1915, that I saw him alive on June 29, 1915, and that death occurred, on the date stated above, at 5:50 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(Duration) about 4 yrs., 0 mos., 0 ds.CONTRIBUTORY (Secondary) Gravimic Emulsion
(Duration) 1 yrs., 0 mos., 0 ds.(Signed) Geo. J. Keller M. D.
6/30, 1915. (Address) 1937 Yonge St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Baltimore Cem

DATE OF BURIAL.

July 2, 1915.

20-UNDERTAKER

Peter Nicolaus

ADDRESS

2046 East 10th

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86374

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86374

CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 644 Jasper street, St. 17 WARD)

2-FULL NAME George W. Crump,

(Residence in Baltimore: No. 644 Jasper street,

St., yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, August 5th, 1874. (Month) (Day) (Year)

7-AGE, 40 yrs., 10 mos., 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Public waiter, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), North Carolina,

10-NAME OF FATHER, Unknown,

11-BIRTHPLACE OF FATHER (State or Country), Unknown,

12-MAIDEN NAME OF MOTHER, Unknown,

13-BIRTHPLACE OF MOTHER (State or Country), Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Gurry, friend,

(Address) 644 Jasper street.

15- JUL 1 - 1915 HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frederick H. Kempel, M. D. (Coroner)

June 30, 1915 (Address) 3310 W. North av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

MA buried 7/1, 1915

20-UNDERTAKER, ADDRESS

Samuel F. Hensley 578 N. Biddle

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *1606 Gough* ST.; *3* WARD)

REGISTERED NO. C.

2—FULL NAME

(Residence in Baltimore: No. *1606 Gough St.* St.; yrs. *6* mos. *27* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3—SEX.

Female

4—COLOR OR RACE.

*White*5—SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6—DATE OF BIRTH.

Dec 8, 1914
(Month) (Day) (Year)

7—AGE.

6 yrs. 27 ds.

If LESS than 1 day, ... hrs. or ... min.?

8—OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer). *Infant*

9—BIRTHPLACE.

(State or Country), *Baltimore*10—NAME OF FATHER, *Julian Magalski*11—BIRTHPLACE OF FATHER (State or Country), *Russian Poland*12—MAIDEN NAME OF MOTHER, *Josephine Karpenski*13—BIRTHPLACE OF MOTHER (State or Country), *Russian Poland*

14—THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Josephine Magalski*(Address) *1606 Gough St.*

15—

JUL 1 - 1915

HARRY O. ANDREWS,

Filed *191* Serial Permit *414* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16—DATE OF DEATH,

June 30, 1915
(Month) (Day) (Year)17— I HEREBY CERTIFY, That I attended deceased from *June 26* 191*5*, to *June 30* 191*5*, that I saw him alive on *June 29* 191*5*, and that death occurred, on the date stated above, at *11* m.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) ... yrs. ... mos. ... ds. *11*CONTRIBUTORY (Secondary) *Pneumonia*(Duration) ... yrs. ... mos. ... ds. *4*(Signed) *J. T. Hies* M. D.*June 30, 1915* (Address) *24 St. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18—LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19—PLACE OF BURIAL OR REMOVAL,

Holy Rosary DATE OF BURIAL *July 1, 1915*

20—UNDERTAKER

William Tialkow ADDRESS *1618 Eastern Ave.*

important. See instructions on back of certificate.

C86376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1712 W Baltimore* ST.; *6* WARD)

2-FULL NAME

Homer A Arnold(Residence in Baltimore: No. *1712 W Baltimore* St.; *63* yrs., *11* mos. *23* ds.)45 C86376
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED, *Married*

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH.

July 7, 1851
(Month) (Day) (Year)

7-AGE.

63 yrs., *11* mos., *23* ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), *Baltimore Md.*10-NAME OF FATHER, *Wm Thompson*

11-BIRTHPLACE OF FATHER

(State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Mary E Brown*

13-BIRTHPLACE OF MOTHER

(State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Arnold*(Address) *1712 W. Baltimore St.*

15-

JUL 1 - 1915

HARRY O. ANDREWS,

Bariat Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 30, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

not 1914, to *June 30* 1915,that I saw h. ed. alive on *June 29* 1915,and that death occurred, on the date stated above, at *3:15* p. m.

The CAUSE OF DEATH* was as follows:

*Cancer of Breast**(Clinical Diagnosis)*(Duration) *9* yrs., *9* mos., *9* ds.

CONTRIBUTORY (Secondary)

(Duration) *9* yrs., *9* mos., *9* ds.(Signed) *W. G. Smith* M. D.*June 3, 1915* (Address) *118 W Calhoun*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Louisa Park Cemetery

DATE OF BURIAL,

July 3, 1915

20-UNDERTAKER

Joe B. Cook

ADDRESS:

1003 W Baltimore St

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86377

CERTIFICATE OF DEATH.

47 C86377
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. No. 18* St.; *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *10 M Carrollton ave* St.; *37* yrs., *10* mos. *29* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Aug 2 1877
(Month) (Day) (Year)

7-AGE,

37 yrs., *10* mos., *29* da. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Housewife*

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER,

Patrick E Tierney

11-BIRTHPLACE OF FATHER (State or Country),

Canada

12-MAIDEN NAME OF MOTHER

Catherine Gilder

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Samuel K. P. Dooney*(Address) *109 Carrollton Ave*

15-

*JUL 1 - 1915.**HARRY O. ANDREWS,*

Filed.....

191

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *June 15 1915*, to *July 1 1915*, that I saw her alive on *July 1 1915* and that death occurred, on the date stated above, at *12:30 P.M.*

The CAUSE OF DEATH* was as follows:

Ac humatic fever.

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *Geo. H. Evans* M. D.*7/1/1915* (Address) *Franklin Sq. No. 18*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State *37* yrs. *10* mos. *29* ds.Where was disease contracted, if not at place of death? *at home*Former or usual residence *10 M Carrollton ave.*

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

July 5, 1915.

20-UNDERTAKER

John B. Cook

ADDRESS

1003 W. Balto St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 PLACE OF DEATH
CITY OF BALTIMORE: (No. *Wm. Gen. Hospital* St.; *3* WARD)
2 FULL NAME *Relda Reigel*
(Residence in Baltimore: No. *1512 Thayer St.* St.; yrs. mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, *Single* WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, *Sept 6, 1891*
(Month) (Day) (Year)
7-AGE, *23* yrs. *8* mos. *24* ds. If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Presser
Shirt

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER, *John H. Reigel*
11-BIRTHPLACE OF FATHER (State or Country) *Balto*
12-MAIDEN NAME OF MOTHER *Alvina Davids*
13-BIRTHPLACE OF MOTHER (State or Country) *Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John H. Reigel*
(Address) *416 S. Collingwood St.*

15- *JUL 1 - 1915* *ROBERT K. KAUTER*
Filed *1915* *Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 30th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 25, 1915*, to *June 30, 1915*, that I saw her alive on *June 30th, 1915*, and that death occurred, on the date stated above, at *6.00 A.M.*

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) *Typhoid Fever*

(Signed) *David Street* M. D.

June 30, 1915 (Address) *712 Park Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1512 Thayer St.*

19-PLACE OF BURIAL OR REMOVAL,

St. Carmel Cem

DATE OF BURIAL,

July 3, 1915

20-UNDERTAKER

J. Herwig & Co.

ADDRESS

2008 Urban

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *405 N. Lakewood Ave* ST. *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *405 N. Lakewood Ave* ST. *57* yrs., *7* mos., *21* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widower*

6-DATE OF BIRTH, *Nov. 8th*, 1838
(Month) (Day) (Year)

7-AGE, *76* yrs., *7* mos., *21* da. If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Fire Brick Manuf'g.*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *John Hoerber*

11-BIRTHPLACE OF FATHER, (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER, (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Theresa Hoerber*(Address) *405 N. Lakewood Ave*15- *JUL 1 - 1915*Filed *JUL 12 1915*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 29th*, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 23rd*, 1915, to *June 29th*, 1915, that I saw him alive on *June 29th*, 1915, and that death occurred, on the date stated above, at *2:50* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
+ Stenophlegia
(Duration) *6* yrs., *6* mos., *6* da.

CONTRIBUTORY (Secondary) (Duration) *6* yrs., *6* mos., *6* da.

(Signed) *Robert P. Scherck* M. D.
June 30th, 1915. (Address) *1318 E. Charles St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *6* yrs., *6* mos., *6* da. In the State *6* yrs., *6* mos., *6* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Matthews Cem.* DATE OF BURIAL, *July 2 1915*

20-UNDERTAKER, *Philip Sterurg* ADDRESS *Oleaus St.*

Important. See instructions on back of certificate.

15. D.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86380

CERTIFICATE OF DEATH

31

C86380

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

ST. 11 WARD)

St. 10 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widowed

6 DATE OF BIRTH

August 9th, 1837
(Month) (Day) (Year)

7 AGE

77 yrs. 10 mos. 21 ds. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE
(State or country)

Virginia U. S. A.

10 NAME OF FATHER

Franklin Minor

11 BIRTHPLACE OF FATHER
(State or country)

Virginia U. S. A.

12 MAIDEN NAME OF MOTHER

Lucy Ann Gilmer

13 BIRTHPLACE OF MOTHER
(State or country)

Virginia U. S. A.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Meredith Janvier

(Address) 14 N. Hamilton St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 30th, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 20th, 1914, to, June 30th, 1915.

that I saw him alive on June 30th, 1915.

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Tubercular peritonitis

Contributory
(SECONDARY)

(Duration) yrs. 9 mos. ds.

Exhaustion

(Duration) yrs. mos. 3 ds.

(Signed) C. W. Mitchell M. D.

July 1, 1915 (Address) 9 C Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Greenmount Cem

DATE OF BURIAL

July 2, 1915

20 UNDERTAKER

C. W. Mitchell & Co.

ADDRESS

1201 W. Fayette St

JUL 1 - 1915.

ROBERT KRAUTER,
Bar 1st Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *Harvard A. Kelly Hospital* ST. *153* WARD)FULL NAME *Winifred Wells*(Residence in Baltimore: No. *1418 Entaw Place* St. *153* yrs. *10* mos. *10* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH,

May 16, 1900
(Month) (Day) (Year)

7-AGE,

15 yrs. 1 mos. 10 ds.

IF LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

School Girl

9-BIRTHPLACE,

(State or Country), *Ashville N.C.*10-NAME OF FATHER, *Horace A. Wells*11-BIRTHPLACE OF FATHER (State or Country), *North Carolina*12-MAIDEN NAME OF MOTHER *Lena Brown*13-BIRTHPLACE OF MOTHER (State or Country), *North Carolina*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *H. A. Wells*(Address) *Ashville N.C.*

15-

*JUL 1 - 1915**ROBERT . KRAUTER*

Filed

191

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 20, 1915*, to *July 11, 1915*, that I saw her alive on *June 30, 1915*, and that death occurred, on the date stated above, at *8 a.m.*

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease(Duration) *4* yrs. *4* mos. *4* ds.

CONTRIBUTORY (Secondary)

(Duration) *4* yrs. *4* mos. *4* ds.(Signed) *Robert H. Lewis* M. D.*July 1, 1915* (Address) *1418 Entaw Pl. City*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *10* yrs. *10* mos. *10* ds. In the State *10* yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Ashville, N.C.*19-PLACE OF BURIAL OR REMOVAL, *Ashville N.C.*DATE OF BURIAL, *July 1, 1915*

20-UNDERTAKER

ADDRESS *Chas. A. Black 1200 W. Mallory St.*

Important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *526 N Maderia*)

FULL NAME

Louise Murray

(Residence in Baltimore: No. *526 N Maderia*)

ST.:

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

24 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House Work

9-BIRTHPLACE,
(State or Country),

va

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- JUL 1 - 1915

Filed..... 191

ROBERT

ERRANDS

Marital Permit Clerk

Registrar.

16-DATE OF DEATH,

June 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry* (Inquest, au-

inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Acute Indigestion*

(Duration) yrs. mos. ds.

(Signed) *Edw. J. Russell* M. D.

June 23, 1915 (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death.... yrs. mos. ds. State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

HOPKINS HOSPITAL

DATE OF BURIAL,

JUL 1 - 1915

20-UNDERTAKER

Commissioner Health,

ADDRESS

FOR ANATOMICAL PURPOSES

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE (No. *2608 Penna Ave* ST. *15* WARD)

2. FULL NAME

(Residence in Baltimore: No. *2608 Penna Ave* St. *15* yrs. *5* mos. *9* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6. DATE OF BIRTH

March 8, 1856
(Month) (Day) (Year)

7. AGE

59 yrs. *9* mos. *23* ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE (State or country)

Baltimore

PARENTS

10. NAME OF FATHER

Charles G. Galt

11. BIRTHPLACE OF FATHER (State or country)

Germany

12. MAIDEN NAME OF MOTHER

Jacqueline Galt

13. BIRTHPLACE OF MOTHER (State or country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harold C. Galt
2608 Penna Ave
(Address)

15. JUL 1 - 1915

ROBERT J. KRAUSE,

Serial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 1, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1, 1913, to *July 1, 1915*.

that I saw her alive on *July 1, 1915*.

and that death occurred, on the date stated above, at *10:27 A.M.*

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic

Contributory (SECONDARY)

Apoplexy

(Signed)

A. G. Pole M. D.

July 1, 1915 (Address) *2038 Madison Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Burial Ground *July 1, 1915*

20. UNDERTAKER

ADDRESS

Geo. W. Lull *2111 Penna Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *900 Homestead* ST. *10* WARD)2-FULL NAME *Mary A Middleton*(Residence in Baltimore: No. *900 Homestead* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female White

4-COLOR OR RACE,

5-SINGLE,

MARRIED, Married
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Feb 27, 1868
(Month) (Day) (Year)

7-AGE,

47 yrs. *4* mos. *1* ds.

IF LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*9-BIRTHPLACE,
(State or Country),*Md*

10-NAME OF FATHER,

James H. Middleton
*Md*11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

*Mary Beck*13-BIRTHPLACE OF MOTHER
(State or Country),*Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Joseph H. Middleton*(Address), *900 Homestead St.*

15- JUL 1 - 1915

Filed..... 191... *Robert H. Middleton* *Notary Public*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 15* 1915, to *July 1* 1915, that I saw him alive on *July 1* 1915, and that death occurred, on the date stated above, at *1 a* m.
The CAUSE OF DEATH* was as follows:*Unusual & Intense*
Microscopic *Brain* *Disease*
(Duration) *1* yrs. *7* mos. *10* ds.CONTRIBUTORY
(Secondary)*Brain* *Person*
(Duration) *1* yrs. *2* mos. *19* ds.(Signed) *Dr. J. W. Hermon* D.*July 1* 1915 (Address) *708 E. Pratt St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Rock Hall Md

DATE OF BURIAL,

July 2 1915

20-UNDERTAKER

Charnow & Son

ADDRESS

Chestnut Ave

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *920 N. Gilmor* ST.; *16* WARD)

FULL NAME

(Residence in Baltimore: No. *920 N. Gilmor* St.; *57* yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-STATUS,

MARRIED, Married
(Write the word.)

6-DATE OF BIRTH,

October 31, 1840
(Month) (Day) (Year)

7-AGE,

74 yrs. 7 mos. 30 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Retail-merchant*
*Tin*9-BIRTHPLACE,
(State or Country),*Carroll Co., Md.*

10-NAME OF FATHER,

*Peter Lineveaver*11-BIRTHPLACE OF FATHER
(State or Country),*Pennsylvania*

12-MAIDEN NAME OF MOTHER

*Maria Husk*13-BIRTHPLACE OF MOTHER
(State or Country),*Pennsylvania*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas. N. Lineveaver

(Address)

1947 Clifton Ave

15-

JUL 1 - 1915.

Filed

ROBERT . KNUTSEN,

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 30, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*June 9, 1915, to June 30, 1915,*that I saw him alive on *June 30, 1915,*and that death occurred, on the date stated above, at *5:30 a.m.*

The CAUSE OF DEATH* was as follows:

Cystitis-nephritis(Duration) yrs. mos. ds. *21 ds.*CONTRIBUTORY (Secondary) *Cystitis & enlarged prostate*(Duration) yrs. mos. ds. *3 yrs. mos. ds.*(Signed) *Wm. C. Todd* M. D.*June 30, 1915.* (Address) *737 N. Gilmor Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Souder Park

DATE OF BURIAL,

July 3, 1915.

20-UNDERTAKER

*H. C. Brauning & Son*ADDRESS *517 N. Schumaker St.*

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86387

CERTIFICATE OF DEATH.

28

C86387

PLACE OF DEATH

University Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

FULL NAME

Abraham Horwitz

Residence in Baltimore: No.

706 W. Fayette St.

St.;

19 yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Unknown, 1896

(Month)

(Day)

(Year)

7-AGE,

19

yrs.

mos.

ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer).

Christian

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

PARENTS.

10-NAME OF FATHER,

Jacob Horwitz

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Mary Kleinman

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. Horwitz

(Address)

706 W. Fayette St.

JUL 2 - 1915.

HARRY O. ANDREWS,

Filed.....

191

Baltimore

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1-15 (220 p.m.) 1915, to July 1-22 p.m. 1915,

that I saw him alive on July 1, 1915,

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Pulmonalis

CONTRIBUTORY (Secondary)

(Duration) 5 yrs. 10 mos. 10 ds.

(Signed) Harry O. Andrews, M. D.

July 1, 1915. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs. 10 mos. 10 ds. In the State 19 yrs. 10 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

706 W. Fayette St.

19-PLACE OF BURIAL OR REMOVAL,

Beverly Road

DATE OF BURIAL,

July 2, 1915.

20-UNDERTAKER

S. Hinson & Bro

ADDRESS

1197 E. Baltimore St.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 W Preston ST.; 11 WARD)

REGISTERED No. C

2-FULL NAME

Edward Frazier

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 304 W Preston St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

Unknown, 1879
(Month) (Day) (Year)

7-AGE.

36 yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which

employed (or employer).

Labor
General

9-BIRTHPLACE.

(State or Country).

South Carolina

10-NAME OF FATHER.

Not known

11-BIRTHPLACE OF FATHER.

(State or Country).

Not known

12-MAIDEN NAME OF MOTHER.

Not known

13-BIRTHPLACE OF MOTHER.

(State or Country).

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet Easton(Address) 916 Penna ave

15-

Filed

JUL 2 - 1915HARRY O. ANDREWS,1915 Marital Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July - 1st, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from June 23 1915, to July 1 1915, that I saw him alive on June 30 1915, and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia & Pleurisy
(20-yr)

(Duration) yrs. mos. ds.

CONTRIBUTORY Heart Failure
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Samuel A. Bui M. D......, 191... (Address) 937 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Laurel Cemetery

DATE OF BURIAL.

July 3, 1915

20-UNDERTAKER

Harriet Easton

ADDRESS

916 Penna ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 E Lombard ST.; 2 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Joseph Thomas MurphyResidence in Baltimore No. 1721 E Lombard St. St.; 5 yrs., 5 mos., 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Male</u>	4-COLOR OR RACE, <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <u>Infant</u> (Write the word.)
6-DATE OF BIRTH, <u>January 25, 1915</u> (Month) (Day) (Year)		
7-AGE, <u>5</u> yrs., <u>5</u> mos., <u>5</u> ds.		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)		

9-BIRTHPLACE,
(State or Country),Baltimore Md.

PARENTS.

10-NAME OF FATHER,

Michael Murphy11-BIRTHPLACE OF FATHER
(State or Country),Baltimore Md.

12-MAIDEN NAME OF MOTHER

Mary Bermingham13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Murphy(Address) 1721 E Lombard St.

15-

HARRY O. ANDREWS,Filed JUL 2 1915 Serial Permit 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 30, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 30 1915, to June 30 1915, that I saw him alive on June 30 1915, and that death occurred, on the date stated above, at 9:10 Pm.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) 1 yrs., 1 mos., 1 ds.
CONTRIBUTORY Significant
(Secondary)

(Duration) 1 yrs., 1 mos., 1 ds.
(Signed) J. L. Valentini M. D.
July 1, 1915 (Address) 16 E. B. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs., 5 mos., 5 ds. In the State 5 yrs., 5 mos., 5 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Holy Cross Cemetery July 2, 1915

20-UNDERTAKER

ADDRESS

Winchell Shapell & Son 27 S. Ann St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86390

CERTIFICATE OF DEATH.

28 C86390

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *Med. General Hospital* ST.; *11* WARD) REGISTERED NO. C
2-FULL NAME *Bertha Washington*
(Residence in Baltimore: No. *1214 Park Avenue* St.; *1* yrs., *11* mos., *-* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. *Female* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)
6-DATE OF BIRTH, *Unknown*, 1 (Month) (Day) (Year)
7-AGE, *1* yrs., *11* mos., *-* ds. IF LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *David A. Washington*
11-BIRTHPLACE OF FATHER (State or Country), *Va*
12-MAIDEN NAME OF MOTHER, *Emmeline Washington*
13-BIRTHPLACE OF MOTHER (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *David A. Washington*
(Address) *1214 Park Ave*

15- JUL 2 - 1915. HARRY O. ANDREWS, Registrar.
Filed..... 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July*, *1*, 191*5*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 25* 191*5*, to *July 1* 191*5*, that I saw her alive on *July 1* 191*5*, and that death occurred, on the date stated above, at *10 A.M.*
The CAUSE OF DEATH* was as follows:

Tubercular Meningitis
(Duration).....yrs.....mos.....*7* ds.

CONTRIBUTORY *Pulmonary Tuberculosis*
(Secondary)

(Duration).....yrs.....mos.....*7* ds.
(Signed) *Charles O. Brown* M. D.
July 1....., 191*5*. (Address) *5 E. Bond St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....*7* ds. In the State.....yrs.....mos.....*7* ds.

Where was disease contracted, if not at place of death? *?*

Former or usual residence *1214 Park Avenue*

19-PLACE OF BURIAL OR REMOVAL, *mt. Auburn* DATE OF BURIAL, *July 2*, 191*5*.

20-UNDERTAKER *Felix B. Pye* ADDRESS *102 E. Mulberry*

important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

OF BALTIMORE (No. 1020 Rutland avenue,

ST.

WARD)

2-FULL NAME Edward H. A. Wehrhahn,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1020 Rutland avenue,

St. 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male,

4-COLOR OR RACE

White,

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married,

6-DATE OF BIRTH

February 10th, 1843.

(Month)

(Day)

(Year)

7-AGE

72 yrs. 4 mos. 20 ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

Clothing cutter,

9-BIRTHPLACE

(State or country)

Germany,

10-NAME OF
FATHER

Henry Wehrhahn,

11-BIRTHPLACE
OF FATHER
(State or country)

Germany,

12-MAIDEN NAME
OF MOTHER

Unknown,

13-BIRTHPLACE
OF MOTHER
(State or country)

Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie Wehrhahn, wife,

(Address) 1020 Rutland avenue.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 30th, 1915.

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 29th, 1915, to June 30th, 1915.

that I saw him alive on June 29th, 1915,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(Duration) yrs. 1 mos. ds.

Contributory Cardiac dilatation,
(SECONDARY)

(Duration) yrs. pos. 7 ds.

(Signed) J. Frederick Humpel, M. D.
June 30, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery July 3rd, 1915.

20-UNDERTAKER

ADDRESS

J. Sander 1714 Fleet St

15 JUL 2 - 1915

HARRY O. ANDREWS,

Sanitary Permit Clerk

REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86392

C86392

CERTIFICATE OF DEATH

28
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 S Potomac St. 1 WARD)

2-FULL NAME Augustus Baker

(Residence in Baltimore: No. 106 S Potomac St. - yrs. - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RW out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

Jan 28

(Day)

1851 (Year)

7-AGE

64 yrs. 5 mos. 1 ds.

If LESS than

1 day, hrs.,

min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Miner

9-BIRTHPLACE

(State or country)

MD

10-NAME OF FATHER

Christopher Baker

11-BIRTHPLACE OF FATHER

(State or country)

Germany

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER

(State or country)

not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elizabeth Baker

(Address)

106 S Potomac

15-

JUL 2 - 1915

HARRY O. ANDREWS,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 29, 1915, to June 29, 1915,

that I saw him alive on June 28, 1915,

and that death occurred, on the date stated above, at 9:15 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis
Duration 1 yrs 0 mos 0 ds.

Contributory (SECONDARY)

(Signed) J. H. Lushbaugh M. D.
June 30, 1915 [Address] 3100 K. Road

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Clark Lawn

DATE OF BURIAL

July 3, 1915

20-UNDERTAKER

H. Sander & Sons 1710 Fleet St.

C86393

HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.

C86393

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427

2-FULL NAME

(Residence in Baltimore: No. 1427

ST. 9

64
REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH

Oct 20

(Month)

20

(Day)

1830

(Year)

7-AGE

84

yrs.

8

mos.

10

da.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

House Work

9-BIRTHPLACE
(State or Country).

Ireland

10-NAME OF FATHER

William Miller

11-BIRTHPLACE OF FATHER
(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Elizabeth Oliver

13-BIRTHPLACE OF MOTHER
(State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Julia L. Miller

(Address)

710 Gladstone Ave.

15-

JUL 2 - 1915

HARRY O. ANDREWS,

Municipal Health Officer,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 30, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 25, 1915, to June 30, 1915, that I saw her alive on June 30, 1915, and that death occurred, on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:Cerebral thrombosis
Right Hemiplegia
(Duration) ... yrs. ... mos. ... da.CONTRIBUTORY
(Secondary)(Signed) Harry O. Andrews, M. D.
July 1, 1915. (Address) 10 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

da.

In the

State

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Greenmount Cemetery
William Cook

DATE OF BURIAL

July 2, 1915

ADDRESS

532 E. North Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 N. Mulberry ST.; 4 WARD)

FULL NAME

(Residence in Baltimore: No. 707 N. Mulberry St.; 46 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

Feb. 8th, 1846
(Month) (Day) (Year)

7-AGE,

69 yrs. 4 mos. 22 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House Duties

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

John G. Gloss

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

William J. Reinhardt
707 N. Mulberry St.

15- JUL 2 - 1915. HARRY O. ANDREWS,

Filed..... 191

Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 30th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 1915 to June 30 1915,

that I saw her alive on June 29 1915,

and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Endocarditis

(Duration) yrs. mos. ds.

(Signed) Oliver B. Freeman, M. D.

July 1., 1915 (Address) 412 Catheher St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cem. July 2., 1915.

20-UNDERTAKER,

ADDRESS

Mrs. John W. Taylor 801 N. Fayette St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

2. FULL NAME

Residence in Baltimore: No.

St.:

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX.

4. COLOR OR RACE.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6. DATE OF BIRTH.

7. AGE.

If LESS than 1 day,hrs. ormin.?

8. OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE, (State or Country),

10. NAME OF FATHER.

11. BIRTHPLACE OF FATHER (State or Country),

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country),

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15.

JUL 2 - 1915

HARRY O. ANDREWS,

Filed.....

1915

Baltimore, Md.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH,

June 30, 1915.
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 17th 1915, to June 30th 1915, that I saw him alive on June 29th 1915, and that death occurred, on the date stated above, at 10:10 a.m.

The CAUSE OF DEATH* was as follows:

Intermittent Nephritis
(Duration) 2 yrs. 2 mos. 2 ds.
CONTRIBUTORY (Secondary) Pharyngitis
(Duration) 2 yrs. 2 mos. 2 ds.
(Signed) J. H. Owens M. D.
June 30, 1915. (Address) 607 W. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mont Auburn Cem July 2, 1915.

20. UNDERTAKER

ADDRESS

John H Owens 1222 Dunbar St

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86396

C86396

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1815 Walbrook Ave., ST. 15 WARD)

2-FULL NAME

Reney A. Hurley

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1815 Walbrook Ave., St. - yrs. - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
(Write the word)

6-DATE OF BIRTH June 28, 1833
(Month) (Day) (Year)

7-AGE 81 yrs. 11 mos. 3 ds. or - min.?
If LESS than 1 day, hrs.

8-OCCUPATION None
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Md.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. C. Price

(Address)

1813 Walbrook Ave.

15-JUL 2 - 1915

HARRY O. ANDERSON,

Serial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I attended deceased from Apr. 15, 1915, to July 1, 1915, that I saw him alive on June 30, 1915, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows: Arterio-sclerosis
myocarditis
fractured femur (3 weeks)
accidental fall on the floor
(Duration) 5 yrs. - mos. - ds.

Contributory Cardiac Asthenia
(SECONDARY) (Duration) 1 yrs. - mos. - ds.

(Signed) R. C. Metzger M. D.
July 2, 1915 (Address) R. C. Metzger

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death - yrs. - mos. - ds. In the State - yrs. - mos. - ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park

July 4, 1915

20-UNDERTAKER

ADDRESS

Josiah Sypher 1600 N. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *24 E. Madison* ST.; *11* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Mary Williams*(Residence in Baltimore: No. *24 E. Madison* St.; *—* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *Dec 25th*, 18*17*
(Month) (Day) (Year)

7-AGE, *97* yrs., *6* mos., *6* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *James Williams*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER *Mary Stumpf*

13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *R. S. Williams*(Address) *va*15- *HARRY O. ANDREWS,**JUL 2 - 1915*, Serial Permit *0191*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 15th*, 191*5*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 15th* 191*5*, to *June 30th* 191*5*, that I saw her alive on *June 30th* 191*5*, and that death occurred, on the date stated above, at *4:40 a.m.*

The CAUSE OF DEATH* was as follows:

*Fracture of the femur
on date stated above,
(accidental fall)
(in bed room)*

CONTRIBUTORY *Sepsis infection from
(Secondary) bedsores* 36 *4* *1/2* *inches*

(Signed) *Eleanor C. Drake, M. D.*
July 15, 1915 (Address) *1012 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Greenmount*DATE OF BURIAL, *July 21, 1915*20-UNDERTAKER, *Howe & Sons*ADDRESS *1012 Madison Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(over)

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86398

186 C86398

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Not known, 1

(Month)

(Day)

(Year)

7-AGE

36

YRS.

mos.

ds.

IF LESS than

1 day, hrs.

or min. 7 -

8-OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employed)

Laborer
General

9-BIRTHPLACE

(State or country)

Bohemia

10-NAME OF FATHER

Josef Schultz

11-BIRTHPLACE OF FATHER
(State or country)

Bohemia

12-MAIDEN NAME OF MOTHER

Josefa Straka

13-BIRTHPLACE OF MOTHER
(State or country)

Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sophia Schultz
28 Cypress St

(Address)

15.

JUL 2 - 1915

HARRY O. ANDREWS,

Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June - 30, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 11, 1915, to June 30, 1915.

that I saw him alive on June 30, 1915,

and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral abscess.

Accident (Duration) 2 yrs. 40 mos. 40 ds.

Contributory (SECONDARY) Penetrating wound, through orbit, piece of steel wire flying from bolt, 40 mos. 40 ds.

(Signed) Jesse B. Downey Jr. M.D.
June 30, 1915 (Address) 429 U. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 19 mos. 15 ds. State 15 yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence 28 Cypress St

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross

July 3, 1915

20-UNDERTAKER

ADDRESS

Frank Cruch Son

19046 Ashland St

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

The man was drinking

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hsp.* ST. *19* WARD)
2-FULL NAME *Joseph Dunson*
(Residence in Baltimore: No. *520 S. Addison St.* St.: — yrs. — mos. — ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *Black* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widowed*
(Write the word.)
6-DATE OF BIRTH. *December 25, 1853*
(Month) (Day) (Year)

7-AGE. *59* yrs. *6* mos. — ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Watchman*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *md.*

10-NAME OF FATHER, *Henry Dunson*
11-BIRTHPLACE OF FATHER (State or Country), *Unknown*
12-MAIDEN NAME OF MOTHER *Unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Phelps*
(Address) *Johns Hopkins Hsp.*

15- JUL 2 - 1915 HARRY O. ANDREWS, Registrar.
First Permit to Bury

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *June 25, 1915*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *May 24* 191*5*, to *June 25* 191*5*, that I saw him alive on *June 25* 191*5*, and that death occurred, on the date stated above, at *11:30* p.m. The CAUSE OF DEATH* was as follows:

Myocardial failure
(Duration) *2* yrs. — mos. — ds.
CONTRIBUTORY (Secondary) *Acute arthritis*
(Duration) — yrs. — mos. — ds.
(Signed) *Frank L. Evans, M.D.*
June 25 191*5* (Address) *Johns Hopkins Hsp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death — yrs. — mos. — ds. In the *59* yrs. *6* mos. — ds. State

Where was disease contracted, if not at place of death?
Former or usual residence: *520 S. Addison St.*

19-PLACE OF BURIAL OR REMOVAL, *Wt Auburn* DATE OF BURIAL, *July 2, 1915*

20-UNDERTAKER, *James H. Linnis* ADDRESS, *1303 Reisterstown Rd.*

Important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86100

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86100

CERTIFICATE OF DEATH.

PLACE OF DEATH *Franklin Square Hosp* 175
CITY OF BALTIMORE (No. *19* WARD)
FULL NAME *Daniel Sopher*
(Residence in Baltimore: No. *1505 W. Lexington* St.; *7* yrs., *9* mos. *7* ds.)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, *Single*
MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH *Sept. 24th, 1907*
(Month) (Day) (Year)
7-AGE, *7* yrs., *9* mos., *7* ds. If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work *School*
(b) General nature of industry, business, or establishment in which employed (or employer).....
9-BIRTHPLACE, (State or Country), *Balto. Md.*
10-NAME OF FATHER, *Samuel Sopher*
11-BIRTHPLACE OF FATHER (State or Country), *Russia*
12-MAIDEN NAME OF MOTHER, *Jennie Sopperstein*
13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *D. Sopher*
(Address) *1505 W. Lexington St.*

15- JUL 2 - 1915
Filed..... 191.....
BARRY O. ANDREWS, Registrar.
Bureau of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 1st, 1915*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Struck by Automobile
Accident
(Duration)..... yrs..... mos..... ds.
CONTRIBUTORY *Septic Infection* (Secondary)
(Duration)..... yrs..... mos..... ds.
(Signed) *Sam'l. Winkler* M. D. (Coroner)
July 2nd, 1915 (Address) *2302 Madison Ave*
State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death..... yrs. *6* mos..... ds. In the *7* yrs. *9* mos. *7* ds. State *7* yrs. *9* mos. *7* ds.
Where was disease contracted, if not at place of death.....
W. Lexington St. Morris Hill
Former or usual residence *1505 W. Lexington*
19-PLACE OF BURIAL OR REMOVAL, *Hebrew Blair Rd.* DATE OF BURIAL, *July 2, 1915*
20-UNDERTAKER, *S. Levinson - Bro. Balto. St.* ADDRESS *1107 E*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86401

CERTIFICATE OF DEATH.

28
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

809 S Grove

ST. 1 WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and put out No. 18.)

2-FULL NAME

Veronica Wojcik

(Residence in Baltimore: No.

809 S. Grove St.

34 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH

Feb

4

1865

(Month)

(Day)

(Year)

7-AGE

50

4

27

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

Housewife

9-BIRTHPLACE,

(State or Country),

Austria

PARENTS.

10-NAME OF

FATHER,

Frank Slowik

11-BIRTHPLACE

OF FATHER

(State or Country),

Austria

12-MAIDEN NAME

OF MOTHER

Zofia Slowik

13-BIRTHPLACE

OF MOTHER

(State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wojciech Wojcik

(Address)

809 S. Grove St.

JUL 2 - 1915

Filed..... 1915

HARRY O. ANDREWS

Serial Form 12-110

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 1, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 10 1915, to July 1 1915,

that I saw her alive on July 1 1915,

and that death occurred, on the date stated above, at 109 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. Unknown

CONTRIBUTORY

(Secondary)

(Duration) yrs. Unknown

(Signed) Dr. Januszko

July 1, 1915 (Address) 2431 Paul Ave.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,

state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or

HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-

SIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Stanislaus Cem July 2, 1915

20-UNDERTAKER

Stephen J. Fealkowski

ADDRESS 1019

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *118 E Barney* ST.; *21* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Frank C Resch*(Residence in Baltimore: No. *118 E Barney* St.; *21* yrs., *1* mos., *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE, *White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *July 24, 1914*

(Month)

(Day)

(Year)

7-AGE, *1* yrs., *5* mos., *8* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Balto.*10-NAME OF FATHER, *Chas Resch*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *Helen Weidmeyer*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Chas Resch*(Address), *118 E Barney*

15-

Filed

JUL 3 - 1915

ROBERT A. KAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *7* *2*, 191*5*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *6/27* 191*5*, to *7/2* 191*5*,that I saw him alive on *7/2* 191*5*,and that death occurred, on the date stated above, at *3:30* m.

The CAUSE OF DEATH* was as follows:

*Gastric Enteritis*Duration *12* yrs., *12* mos., *12* ds.CONTRIBUTORY (Secondary) *Malnutrition*(Duration) *12* yrs., *12* mos., *12* ds.(Signed) *L. J. Deulen* M. D.*7/2*, 191*5*. (Address) *102 E. Fort St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs., *1* mos., *1* ds. In the State *1* yrs., *1* mos., *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cedar Hill Cemetery*DATE OF BURIAL, *July 5, 1915*20-UNDERTAKER, *H. & M. E. Flynn*ADDRESS, *1422 Light St*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 86404

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *33 W. West*ST.: *23* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME

Mary E. Norton(Residence in Baltimore: No. *33 W. West St.*St.: yrs., *6* mos. *4* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

Dec 28, 1914
(Month) (Day) (Year)

7-AGE,

*6 yrs., 4 mos., 4 ds.*If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*9-BIRTHPLACE,
(State or Country),*Balto., Md.*

10-NAME OF FATHER,

*Leo E. Norton*11-BIRTHPLACE OF FATHER
(State or Country),*Balto., Md.*

12-MAIDEN NAME OF MOTHER

*Cecilia M. Cooper*13-BIRTHPLACE OF MOTHER
(State or Country),*Balto., Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Leo E. Norton (Father)

(Address).....

33 W. West St.

15-

JUL 3 - 1915

ROBERT KRAUTER

Filed..... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 28, 1915, to July 2, 1915,
that I saw h. *u* alive on *July 2, 1915,*
and that death occurred, on the date stated above, at *11* m.

The CAUSE OF DEATH* was as follows:

*Entero-Colitis*CONTRIBUTORY
(Secondary)(Duration) *5* yrs. *2* mos. *5* ds.
Exhaustion
(Signed) *J. C. Ferguson* M. D.
7/2, 1915 (Address) *1230 2nd Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

July 4, 1915

20-UNDERTAKER

H. & M. S. Flynn

ADDRESS

1422 Light St

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86405

HEALTH DEPARTMENT—CITY OF BALTIMORE

PLACE OF DEATH

CERTIFICATE OF DEATH

92 C86405

1. CITY OF BALTIMORE (No. 1022 S Sharp

2. FULL NAME Hilda S. Depkin

(Residence in Baltimore: No. 1022 S Sharp St

REGISTERED No. C

ST. 23 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

Married

6. DATE OF BIRTH

October 5, 1886

7. AGE

28 yrs. 8 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE (State or country)

Baltimore Md

10. NAME OF FATHER

Henry C. Henschel

11. BIRTHPLACE OF FATHER (State or country)

Baltimore Md

12. MAIDEN NAME OF MOTHER

Louise Seidel

13. BIRTHPLACE OF MOTHER (State or country)

Baltimore Md

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry C. Depkin (Husband)

(Address) 1022 S Sharp St

15.

JUL 3 - 1915

ROBERT A. KRAUTER

Chief of Bureau

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 30, 1915

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1915, to June 30, 1915.

that I saw her alive on June 30, 1915, and that death occurred, on the date stated above, at 6:10 a.m.

The CAUSE OF DEATH was as follows:

Acute Lobar Pneumonia

Contributory (SECONDARY)

(Duration) yrs. mos. ds. 10

(Signed)

Chas. M. Reinhardt

June 30, 1915 (Address) 1017 S Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted? If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

London Park Cemetery

DATE OF BURIAL

July 3, 1915

20. UNDERTAKER

E. Schloman

ADDRESS 1039

Hanover St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2236 E. Balto*)

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

*Mrs Elizabeth Kellwig*Residence in Baltimore: No. *2236 E. Baltimore*St.; *50* yrs., — mo., — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Married*

6-DATE OF BIRTH,

*Dec**14**1846*

(Month)

(Day)

(Year)

7-AGE,

*68**6**mon.**16**da.*

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country)

Marburg, Germany

10-NAME OF FATHER,

Henry Stamm

11-BIRTHPLACE OF FATHER

(State or Country)

Germany

12-MAIDEN NAME OF MOTHER

Margaret Kellwig

13-BIRTHPLACE OF MOTHER

(State or Country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Henry Stamm

(Address)

2236 E. Baltimore

JUL 3 - 1915

ROBERT KRAUTER,

Burial Permit Clerk.

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*June**30**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 23 1915, to *June 30* 1915.that I saw him alive on *June 29* 1915.and that death occurred, on the date stated above, at *9:30* a.m.

The CAUSE OF DEATH* was as follows:

Arthritis Defarmanus
Endocarditis(Duration) *4* yrs. *6* mos. *—* ds.CONTRIBUTORY (Secondary) *Septic Infection*(Duration) *2* yrs. *—* mos. *—* ds.(Signed) *H. G. Cappage* M. D.*6/30*, 1915. (Address) *1111 North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Loyson Park Cemetery**July 3*, 1915.

20-UNDERTAKER

ADDRESS

*Geo A Gerbig**Baltimore*

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86407

CERTIFICATE OF DEATH

x 113

C86407

PLACE OF DEATH

Church Home Infirmary
Broadway Fairmount

REGISTERED NO. C

CITY BALTIMORE (No.

ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

FULL NAME

Harry Parker Boyd

Residence in Baltimore: No.

Rogers and Green Spring ave Balto 60 Md

Sr. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. MARRIED

married

6. DATE OF BIRTH

August 16, 1863

7. AGE

51 yrs. 10 mos. 16 ds.

8. OCCUPATION

(a) Trade, profession, or particular kind of work Secty. Treasurer
(b) General nature of industry, business, or establishment in which employed (or employer) Nat Bldg Supply

9. BIRTHPLACE
(State or country)

Frederick Md

10. NAME OF FATHER

Wm B. Boyd

11. BIRTHPLACE OF FATHER
(State or country)

Frederick Md

12. MAIDEN NAME OF MOTHER

Elisabeth Roche

13. BIRTHPLACE OF MOTHER
(State or country)

Baltimore Md

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

May L Boyd
Green Spring Rogers

(Address)

JUL 3 - 1915

HARRY O. ANDREWS

Filed

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 2, 1915

17. I HEREBY CERTIFY, That I attended deceased from

June 3, 1915, to July 2, 1915, that I saw him alive on July 2, 1915, and that death occurred, on the date stated above, at 2:22 a.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the liver

Contributory
(SECONDARY)

(Signed) A. F. Robinson M. D.
July 2, 1915 (Address) 141 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 6 mos. 6 ds. State 51 yrs. 10 mos. 16 ds.
Where was disease contracted?
If not at place of death?
Former or usual residence Balto 60 Md

19. PLACE OF BURIAL OR REMOVAL

St Marys Cem Green

DATE OF BURIAL

7-5-1915

20. UNDERTAKER

Henry W. Jenkins

ADDRESS

Orchard Me Cullen St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1119 Greenmount Ave)

2-FULL NAME George John Park

(Residence in Baltimore: No. 1119 Greenmount Ave)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6-DATE OF BIRTH Dec 27, 1912
(Month) (Day) (Year)

7-AGE 2 yrs. 6 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9-BIRTHPLACE
(State or country)

Balt. Md

10-NAME OF FATHER

George R. Park

11-BIRTHPLACE OF FATHER
(State or country)

Balt. Md

12-MAIDEN NAME OF MOTHER

Annie M. Bude

13-BIRTHPLACE OF MOTHER
(State or country)

Balt. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George R. Park

(Address)

1119 Greenmount Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 3, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1915, to July 2, 1915, that I saw him live on July 1, 1915, and that death occurred, on the date stated above, at 1130 a.m.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Contributory
(SECONDARY)

(Duration) 17 ds.

(Duration) 4 ds.

(Signed)

July 2, 1915 (Address) for E. Hamilton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Redeemer Cemetery

DATE OF BURIAL

July 5, 1915

20-UNDERTAKER

Henry Wood

ADDRESS

1301 E. Eager St.

15. JUL 3 - 1915

HARRY O. ANDREWS,

Special Permit Officer

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hwy 10* St.;

WARD)

2-FULL NAME

Adam E. Kirchner(Residence in Baltimore: No. *1022 E. Biddle*

St.; — yrs., — mos., — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

*MARRIED**or DIVORCED,*

(Write the word.)

6-DATE OF BIRTH

February 9

(Month)

(Day)

1865
(Year)

7-AGE.

52

yrs.

4

mos.

23

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Expressman

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER

Christopher Kirchner

11-BIRTHPLACE OF FATHER

(State or Country)

Germany

12-MAIDEN NAME OF MOTHER

Alvord Fox

13-BIRTHPLACE OF MOTHER

(State or Country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Pauline Kirchner*(Address) *1022 E. Biddle*

15-

JUL 3 - 1915

HARRY O. ANDREWS

Filed

Baltimore City Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

(Month)

2

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1 191*5* to *July 2* 191*5*that I saw him alive on *July 2* 191*5*and that death occurred, on the date stated above, at *8:55 a.* m.

The CAUSE OF DEATH was as follows:

*Chronic Interstitial Nephritis**Pneumonia*(Duration).....yrs.....mos.*14* ds.

CONTRIBUTORY

(Secondary)

Tuberculosis(Duration).....yrs.....mos.*24* hrs.(Signed) *A. S. Coleman* M. D.*July 2, 1915* (Address) *University Hwy 10*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.*1* ds. In the State.....yrs.....mos.....ds.Where was disease contracted, if not at place of death? *1022 E. Biddle St*Former or usual residence *Above*

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Cemetery

DATE OF BURIAL,

July 4, 1915

20-UNDERTAKER

Henry John Reed

ADDRESS

1301 E. Bay St.

important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86410

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86410

CERTIFICATE OF DEATH

110

1. PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *2302 N. Fulton Ave*)

ST. *13* WARD)

2. FULL NAME *Henry Budnitz*

Residence in Baltimore: No. *2302 N. Fulton Ave*

St. *60* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widower*
(Write the word)

6. DATE OF BIRTH *September 17, 1834*
(Month) (Day) (Year)

7. AGE *80* yrs. *9* mos. *14* ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country) *Germany*

10. NAME OF FATHER *Andreas Budnitz*

11. BIRTHPLACE OF FATHER (State or country) *Germany*

12. MAIDEN NAME OF MOTHER *Antoniette Sauer*

13. BIRTHPLACE OF MOTHER (State or country) *Germany*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Edmund Budnitz*

(Address) *1727 W. North Ave*

JUL 3 - 1915

Filed

HARRY O. ANDREWS,
Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *July 1, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 29th*, 1915, to *July 1st*, 1915, that I saw him alive on *June 30th*, 1915, and that death occurred, on the date stated above, at *8:40* a.m.

The CAUSE OF DEATH* was as follows:

Obstipation, closing of Intestines
(Duration) = yrs. mos. ds. *6*

Contributory *Pericarditis*
(SECONDARY) (Duration) *Don't know*

(Signed) *Wm. Cornish* M.D.
July 1st, 1915 (Address) *1704 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Balto Cemetery

DATE OF BURIAL

July 3, 1915

20. UNDERTAKER

John W. Bell

ADDRESS

2820 Harlem Ave

C86411

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86411

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed

191.

Burial Permitted

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 9:15 P.m.

The CAUSE OF DEATH* was as follows:

Acute Suppurative
Appendicitis & Peritonitis.
(Duration).....yrs...1...mos...2...ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs...mos...ds.

(Signed) Elmer Newcomer M. D.

July 2, 1915 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutional Transients, or Recent Residents).

At place of death.....yrs...1...mos...22...ds. In the H State.....yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence Westminster Md.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Westminster Md July 1, 1915

20-UNDERTAKER

ADDRESS

James M. Storer Westminster

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86412

C86412

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2024 N. Calvert ST.; 12 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 2024 N. Calvert St.; 20 yrs., ? mos., ? dn.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH

January 14, 1847
(Month) (Day) (Year)

7-AGE

68 yrs., 6 mos., 17 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

U.S. Government

Employ.

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

Augustus Webster

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

Mary J. Hines

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Sally C. Webster

(Address)

2024 N. Calvert St

15-

JUL 3 - 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

1915, to June 27, 1915,

that I saw him alive on July 1, 1915,

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma (Cancer) of the

Bladder (Operation - Necropsy -

Post Mortem)

(Duration) 100 yrs., 6 mos., 17 ds.

CONTRIBUTORY

(Secondary)

(Duration) 100 yrs., 6 mos., 17 ds.

(Signed) John D. King M. D.

July 2, 1915 (Address) 1425 E. Lombard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 100 yrs., 6 mos., 17 ds. In the State 100 yrs., 6 mos., 17 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Loudon Park Cemetery

DATE OF BURIAL.

July 3, 1915

20-UNDERTAKER

Stewart Howenlo

ADDRESS

108 N. North Ave.

Important. See instructions on back of certificate.

C86413

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86413

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2428 E. Preston ST.; 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2428 E. Preston St.; 60 yrs., ? mos., ? ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow
(Write the word.)

6-DATE OF BIRTH. July 17th, 1840
(Month) (Day) (Year)

7-AGE. 74 yrs., 11 mos., 13 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer). none

9-BIRTHPLACE, (State or Country).

Carroll Co. Md.

PARENTS.

10-NAME OF FATHER,

Edward Jones

11-BIRTHPLACE OF FATHER (State or Country),

not known

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER (State or Country),

not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas. A. Dorsett

(Address)

2428 E. Preston St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 30, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 24 1915, to June 30 1915, that I saw h^er alive on June 19 1915, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

General Exhaustion
(old age).(Duration) yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary)

Arterio-sclerosis(Duration) yrs. ? mos. ? ds.(Signed) B. P. Storz, M. D.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Carmel Cemetery July 3, 1915

20-UNDERTAKER

ADDRESS

Stewart Mowen Co 108 W. North Ave.

important. See instructions on back of certificate.

JUL 3 - 1915

HARRY O. ANDREWS,

Filed..... 1915

Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86414

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86414

CERTIFICATE OF DEATH.

36

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1635 N. Calhoun street, St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Turner,

(Residence in Baltimore: No. 1635 N. Calhoun street, St.; yrs., /0 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, August 24th, / 914. (Month) (Day) (Year)

7-AGE, 0 yrs., 10 mos., 8 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Thomas Turner,

11-BIRTHPLACE OF FATHER, Baltimore, Md. (State or Country),

12-MAIDEN NAME OF MOTHER, Carrie Flood,

13-BIRTHPLACE OF MOTHER, Baltimore, Md. (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Carrie Turner, mother, (Address) 1635 N. Calhoun street.

15- JUL 3 - 1915 HARRY O. ANDERSON, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 2nd, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Rachitis, (Duration) yrs. mos. ds.

CONTRIBUTORY Artificially fed, (Secondary) (Duration) yrs. mos. ds. (Signed) J. Frederick Thompson, M. D. (Coroner.) July 3d, 1915, (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Catholic Church, DATE OF BURIAL, July 3, 1915.

20-UNDERTAKER, 1364 Perry

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 217 S. Mount St. 19 WARD)

2-FULL NAME Thomas Norton Gillen

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 217 S. Mount St. St.; — yrs. 5 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE white 5-SINGLE single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH January 7, 1915
(Month) (Day) (Year)

7-AGE 5 yrs. 25 mos. 25 ds. or min.?
If LESS than 1 day, hrs., min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
none

9-BIRTHPLACE
(State or country)
Bald City

10-NAME OF FATHER Joseph Francis Gillen

11-BIRTHPLACE OF FATHER
(State or country) Bald City

12-MAIDEN NAME OF MOTHER Annie R. Schmitt

13-BIRTHPLACE OF MOTHER
(State or country) Bald City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Annie Gillen

(Address) 217 S. Mount St.

JUL 3 - 1915

Filed 1915 Serial 10010 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1915, to, July 2, 1915,
that I saw him alive on July 2, 1915,
and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Colloidal (coma)

(Duration) — yrs. — mos. — ds.
Contributory (SECONDARY) Gastro-Enteritis

(Signed) Wm. F. Blaney M. D.
July 2, 1915. [Address] 1103 S. Guilford St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Cathedral Cem. July 4, 1915

20-UNDERTAKER ADDRESS
John B. Cook 1003 W. Baltimore

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C864113

169 C864113

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 906 W Lexington ST. 18 WARD)
FULL NAME William Dunn
(Residence in Baltimore: No. 906 W Lexington St.; yrs. 40 mos. 10 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
6-DATE OF BIRTH, unknown, 1
7-AGE, 50
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9-BIRTHPLACE, (State or Country), Ireland
10-NAME OF FATHER, John Dunn
11-BIRTHPLACE OF FATHER (State or Country), Ireland
12-MAIDEN NAME OF MOTHER, Mary Cassidy
13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Cecilia Dunn
(Address) 906 W Lexington

15 JUL 3 - 1915
Filed....., 1915
HARRY O. ALLEN, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 2, 1915
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence obtained by said inquest, and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Drowning - accidental
CONTRIBUTORY (Secondary) Cardiac Depletion
(Signed) J. J. Jeffers M. D.
July 3, 1915. (Address) 113 N Carrollton Ave
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral
20-UNDERTAKER, Joe Block
DATE OF BURIAL, July 5, 1915
ADDRESS, 103 N Balto St

At delivery item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

11 LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

16-

HARRY O. ANDREWS,

Barial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *508 N. Fayette St.* ST.: *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Elsie May Talbot*(Residence in Baltimore: No. *508 N. Fayette St.* St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

October 12, 1900
(Month) (Day) (Year)

7-AGE.

14 yrs. 8 mos. 21 ds.

If LESS than 1 day.

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE, (State or Country).

Ind

10-NAME OF FATHER.

Oliver Talbot

11-BIRTHPLACE OF FATHER

(State or Country).

Ind.

12-MAIDEN NAME OF MOTHER

Frazer Foster

13-BIRTHPLACE OF MOTHER

(State or Country).

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Oliver Talbot

(Address)

508 N. Fayette St.

15-

Filed *3* 1915

191

HARRY O. ANDREWS,

Baptist Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 2nd, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 30th 1915*, to *July 2nd 1915*, that I saw her alive on *July 2nd 1915*, and that death occurred, on the date stated above, at *8 P.M.*

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Neutral Resuscitation(Duration) *3* yrs. ... mos. ... ds.(Signed) *Geo. H. Mungatroy, M.D.* D.*July 2nd 1915* (Address) *7537 Sherman St. Cr.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

St. Olivet

DATE OF BURIAL.

July 4, 1915

20-UNDERTAKER

J. S. Marshall 3539 Fall Road

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86419

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86419

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No. 1013 X Chapel St

ST.: 7

WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

April 8th, 1880
(Month) (Day) (Year)

7-AGE,

35 yrs. 2 mos. 22 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,
(State or Country),

md.

10-NAME OF FATHER,

Wm Hall

11-BIRTHPLACE OF FATHER
(State or Country),

md

12-MAIDEN NAME OF MOTHER

Mary Bradley

13-BIRTHPLACE OF MOTHER
(State or Country),

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Burns

(Address) 1013 X Chapel

15-

JUL 3 - 1915

HARRY O. ANDREWS,

101 Barial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 30th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

(Suicide) Carbolic Acid

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Elyah J. Russell M. D.
(Coroner.)

July 1st, 1915 (Address) 423 X Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

Asbury Cemetery

DATE OF BURIAL,

July 3rd, 1915

20-UNDERTAKER

John H Owens

ADDRESS

1222 Dunes

18. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86420

64 C86420

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

Residence in Baltimore: No.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow*
(Write the word)

6 DATE OF BIRTH *Feb 13*, 1852
(Month) (Day) (Year)

7 AGE *63* yrs. *4* mos. *18* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

9 BIRTHPLACE
(State or country)

Germany

10 NAME OF FATHER

M. Salchow

11 BIRTHPLACE OF FATHER
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

M. Mousselle

13 BIRTHPLACE OF MOTHER
(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. W. Schaub

(Address)

705 N Howard St

15 JUL 3 - 1915 HARRY O. ANDREWS,

Filed 1915 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 12*, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 1st*, 1915, to *July 1st*, 1915, that I saw him alive on *July 1st*, 1915, and that death occurred, on the date stated above, at *4 P.* m. The CAUSE OF DEATH* was as follows:

Apoplexy

Contributory (Duration) *2* yrs. *2* mos. *2* ds. *General Arterio-sclerosis*
(SECONDARY)

(Signed) *Edw. M. Fitzgerald* M. D. *July 2*, 1915 (Address) *571 Washington St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cemetery

July 14, 1915

20 UNDERTAKER

ADDRESS

Mrs. A. Rohde

730 Puller

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86421

CERTIFICATE OF DEATH

REGISTERED No. C.

C86421

PLACE OF DEATH

CITY OF BALTIMORE: (No.

3-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and add out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widowed

6-DATE OF BIRTH

Unknown

7-AGE

75

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (for employer)

Domestic

9-BIRTHPLACE
(State or country)

Va.

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER
(State or country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mathe Lee
602 Bradley

15-

FILED

JUL 3 - 1915

HARRY O. ANDREWS,
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6, 1915, to July 1, 1915, that I saw her alive on June 29, 1915, and that death occurred, on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. ds. 12

Contributory
(SECONDARY)

Arterio sclerosis

(Duration) yrs. mos. ds. 6

(Signed)

H. S. McLeod

7/3, 1915 [Address] 2005 2nd St. N. W.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Auburn

DATE OF BURIAL

July 3, 1915

20-UNDERTAKER

Samuel T. Hemmley 578 N. Biddle St.

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86422 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

670 S. Fulton Ave

John H. Chapman

670 S. Fulton Ave

ST.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

St. 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

male

COLOR OR RACE

White

SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

DATE OF BIRTH

May

10th, 1840

(Month)

(Day)

(Year)

AGE

74

yrs.

10

mos.

20

ds.

IF LESS than

1 day, hrs.

or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Park Police

(b) General nature of industry, business, or establishment in which employed (or employer)

David H. H. Park

BIRTHPLACE

(State or country)

Charlestown La

NAME OF FATHER

Unknown

BIRTHPLACE OF FATHER

(State or country)

Charlestown La

MAIDEN NAME OF MOTHER

Unknown

BIRTHPLACE OF MOTHER

(State or country)

Charlestown La

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ornette F. Pascoe

(Address)

1309 N. Lombard St

15

JUL 3 - 1915

Filed

191

DANIEL V. ARDEN, JR.

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

June

30

1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

November, 1912, to June 26, 1915,

that I saw him alive on June 26, 1915,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

Chronic valvular heart disease

(Duration) 3 or 4 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Thornage Long Nichols, M. D.

June 30, 1915 (Address) 535 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Landon Park Cemetery

July 3rd, 1915

UNDERTAKER

ADDRESS

F. B. Huppert 2728 Fredk Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86423

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86423

CERTIFICATE OF DEATH

132
REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.)

2-FULL NAME

Residence in Baltimore: No.

Hebrew Hospital Baltimore

May Wolf

Hebrew Hospital

St.; 44 yrs. - mos. 2 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM. set No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR-DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

FIN

HARRY O. ANDERSON

Serial Permit 010

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed),

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

C86421

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86421

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *5* WARD)3-FULL NAME *Joseph Julian Forman*(Residence in Baltimore: No. *1013 E. Monument* St. *4* yrs. *4* mos. *20* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

*white*5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*child*

6-DATE OF BIRTH

*February**13**11915*

7-AGE

4 yrs. *20* mos. *20* ds.If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*child*9-BIRTHPLACE
(State or country)*Baltimore*

10-NAME OF FATHER

*Israel Forman*11-BIRTHPLACE OF FATHER
(State or country)*Baltimore*

12-MAIDEN NAME OF MOTHER

*Jessie Gold*13-BIRTHPLACE OF MOTHER
(State or country)*London*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. Lewis*(Address) *1419 E. Baltimore*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*July**3**1915*17- I HEREBY CERTIFY, That I attended deceased from *July 2*, 1915, to *July 3*, 1915, that I saw him alive on *July 3*, 1915, and that death occurred, on the date stated above, at *11:30 p.m.*
The CAUSE OF DEATH* was as follows:*Intestinal Obstruction*Contributory
(SECONDARY)*none*(Signed) *M.B. Lewis**July 3*, 1915[Address] *Hebrew Hosp*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, *36* yrs. *36* mos. *36* ds. in the State *4* yrs. *4* mos. *20* ds.Where was disease contracted, if not at place of death? *1013 E. Monument*Former or usual residence *1013 E. Monument St*

19-PLACE OF BURIAL OR REMOVAL

Hebrew Hospital

DATE OF BURIAL

7/4, 1915

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Baltimore

THIS CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

15-

4 - 1915

HARRY O. ANDREWS,

Bureau Permit Clerk

REGISTRAR

C86425

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1509 E Monument St.)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Lucy May Brown

(Residence in Baltimore: No. 1509 E Monument

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Female</i>	4-COLOR OR RACE, <i>Colored</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>Single</i> (Write the word.)
6-DATE OF BIRTH, <i>Feb 21, 1901</i> (Month) (Day) (Year)		
7-AGE, <i>14 yrs. 4 mos. 9 ds.</i>		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		
<i>School Girl</i>		
9-BIRTHPLACE, (State or Country), <i>M D</i>		
PARENTS.	10-NAME OF FATHER, <i>Wesley Brown</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>M D</i>	
	12-MAIDEN NAME OF MOTHER <i>Mary F Coose</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Washington D C.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

JUL 4 - 1915

HARRY O. ANDREWS,

Serial Permit Clerk

Registrar.

ST.

7

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 2nd, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest*
(Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes
Bronchitis 1 year ago
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)(Signed) *Elijah F. Russell* M. D.
(Coroner.)
July 2nd, 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*Laurel Cem.**July 4th 1915*

20-UNDERTAKER

ADDRESS

*Harry A. Vodrey**1735 Belmont St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86426

C86426

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *904 N. Durban St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *904 N. Durban St.*)St.; *30* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

6-DATE OF BIRTH *not known*, 1 (Month) (Day) (Year)

7-AGE *83* If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Bohemia*

PARENTS.
10-NAME OF FATHER *Not known*
11-BIRTHPLACE OF FATHER (State or Country), *Not known*
12-MAIDEN NAME OF MOTHER *Not known*
13-BIRTHPLACE OF MOTHER (State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Magdalena Kral*(Address) *904 N. Durban St.*

15-

Filed *JUL 4 1915* HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 3, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY That I attended deceased from *May 1, 1915* to *July 3, 1915*, that I saw her alive on *July 3, 1915*, and that death occurred, on the date stated above, at *2 A*

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(Duration) *4* yrs., mos. da.

CONTRIBUTORY (Secondary)

(Signed) *W. J. Ryan* M. D.
July 3, 1915 (Address) *208 S. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer*DATE OF BURIAL, *July 5, 1915*20-UNDERTAKER *Frank Coachman*ADDRESS *1904 ...*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 East Baltimore ST.; 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No. 1127 E. Baltimore St. 36 yrs., 1 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Widow

6-DATE OF BIRTH,

(Month) 1 (Day) 1 (Year) 1915

7-AGE,

46 yrs. 0 mos. 0 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none9-BIRTHPLACE,
(State or Country),Mulhoush
Prince Georges, Md

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),Benj. F. WestfieldGermanJulia Ann GrayMd

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Benj. F. Westfield

(Address)

618 Grand St., Waverly

15-

JUL 4 - 1915HARRY O. ANDREWS

Filed

1915Serial Permit 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 3, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 12 1915, to July 3 1915, that I saw her alive on July 2 1915, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Cancer(Duration) 2 yrs. 4 mos. 0 ds.CONTRIBUTORY
(Secondary)Nephritis (Duration) 6 mos. 0 ds.

(Signed)

7/3/15, 1915 (Address) 802 Truitt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

July 4, 1915

20-UNDERTAKER

Henry W. Meas & Son

ADDRESS

705 N. Calvert St.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86428

CERTIFICATE OF DEATH.

x 30

PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.; *7* WARD)FULL NAME *Edomia Seth*(Residence in Baltimore: No. *1607 S. Clinton St.* Baltimore Md. St.; *—* yrs., *—* mos., *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE.

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

6-DATE OF BIRTH.

*June**25**1914*

(Month)

(Day)

(Year)

7-AGE.

1 yrs., *7* mos., *7* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Infant*

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

John Seth

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Minnie Raine

13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *R. Blum*(Address) *174 Hope*

15 JUL 4 - 1915

HARRY O. ANDREWS,

Filed..... 191... *2-12-15* Permit *0109*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**2**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 2, 191*5*, to *July 2*, 191*5*,that I saw her alive on *July 2*, 191*5*,and that death occurred, on the date stated above, at *4:40* m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis(Duration) *3* yrs., *3* mos., *3* ds.CONTRIBUTORY (Secondary) *none*(Duration) *—* yrs., *—* mos., *—* ds.(Signed) *G. A. Raine* M. D.*July 2*, 191*5* (Address) *J. H. Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *4 1/2* mos. *1* yr., *7* ds.Where was disease contracted, if not at place of death? *✓*Former or usual residence *1607 S. Clinton St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

not buried July 4 1915

20-UNDERTAKER

ADDRESS

G. L. Blount 30108 m...

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86430

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *410 E. Fort Ave.* ST.; *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *410 E. Fort Ave.*St.; *53* yrs., *3* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

April 1, 1862
(Month) (Day) (Year)

7-AGE,

53 yrs., *3* mos., *0* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Watchman*
(b) General nature of industry, business, or establishment in which employed (or employer) *Phil. S. B. Co.*

9-BIRTHPLACE, (State or Country),

Balto. Md.

10-NAME OF FATHER,

Thomas Shent.

11-BIRTHPLACE OF FATHER (State or Country),

Not known.

12-MAIDEN NAME OF MOTHER

Mary L. Turner.

13-BIRTHPLACE OF MOTHER (State or Country),

Not known.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Minnie Shent (Wife)

(Address)

410 E. Fort Ave.

15-

JUL 4 - 1915

HARRY O. ANDREWS,

Filed

1915 JUL 4 PM 11 01

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *June 25* 1915, to *July 1* 1915, that I saw him alive on *July 1* 1915, and that death occurred, on the date stated above, at *8:20* p.m.

The CAUSE OF DEATH* was as follows:

chronic interstitial nephritis
strict(Duration) *1* yrs., *6* mos., *6* ds.

CONTRIBUTORY (Secondary)

(Duration) *6* yrs., *6* mos., *6* ds.(Signed) *Morris Jones* M. D.*July 2, 1915* (Address) *410 E. Fort Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Ceder Hill Cem.

DATE OF BURIAL,

July 9, 1915

20-UNDERTAKER

Edward L. Fanning, 1760 Battery

ADDRESS

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *617 S Luzerne* ST. *1* WARD)2-FULL NAME *Helen Petro (PETRO)*(Residence in Baltimore: No. *617 S Luzerne* St.; yrs., *6* mos. *8* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) *Single*6-DATE OF BIRTH, *Dec 24, 1914*

(Month)

(Day)

(Year)

7-AGE, *6* mos. *8* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *John Petro*11-BIRTHPLACE OF FATHER (State or Country), *Austria*12-MAIDEN NAME OF MOTHER *Rose Kmilewski*13-BIRTHPLACE OF MOTHER (State or Country), *Austria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Petro*(Address) *617 S Luzerne*

15-

Filed

JUL 4 - 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 2, 1915*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *July 20* 191*5*, to *July 2* 191*5*that I saw him alive on *July 2* 191*5*, and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH* was as follows:

Marasmus

CONTRIBUTORY (Secondary)

Heart Condition

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Rosary*DATE OF BURIAL, *July 4, 1915*20-UNDERTAKER *Jacob Fialkowski*ADDRESS *428 S Bond St*

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *813 E Eager*)

FULL NAME

(Residence in Baltimore: No. *813 E Eager*)

St.: *10* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>Married</i>
6-DATE OF BIRTH, <i>May 20th, 1867</i> (Month) (Day) (Year)		
7-AGE, <i>48 yrs. 1 mos. 12 ds.</i>		If LESS than 1 day, ...hrs. or ...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		

9-BIRTHPLACE,
(State or Country),

Ireland

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Hession*

(Address) *813 E. Eager St.*

15- JUL 4 - 1915.

HARRY O. ANDREWS,

Filed..... 191.....

Register.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 2nd, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry*
(Inquest, au-

Inquiry and that said deceased came to death of the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *Olga R. Russell* M. D.
(Coroner.)

July 2nd, 1915 (Address) *475 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Holy Cross July 5, 1915

20-UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Granmont Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86433

CERTIFICATE OF DEATH.

28

PLACE OF DEATH

CITY OF BALTIMORE: (No. *604 S. Port* ST.; *1* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

FULL NAME *Archer W. Garner*Residence in Baltimore: No. *604 S. Port*St. *25* yrs., *25* mon. *25* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 21st, 1871
(Month) (Day) (Year)

7-AGE,

44 yrs. *2* mos. *12* ds.If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Driver*
*Butcher Wagon*9-BIRTHPLACE,
(State or Country),*Virginia*

10-NAME OF FATHER,

A. H. Garner

11-BIRTHPLACE OF FATHER

(State or Country),

V. A.

12-MAIDEN NAME OF MOTHER

Ann E. Yancey

13-BIRTHPLACE OF MOTHER

(State or Country),

Ark.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lena Archer*(Address) *604 S. Port St.*

15-

JUL 4 - 1915.

HARRY O. ANDERSON,

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 3, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 29, 1915*, to *July 3, 1915*, that I saw him alive on *July 3, 1915*, and that death occurred, on the date stated above, at *11:50 p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *1* yrs. *3* mos. *3* ds.

CONTRIBUTORY (Secondary)

Exhaustion(Duration) *3* yrs. *3* mos. *3* ds.(Signed) *O. L. Fort**July 4, 1915* (Address) *2701 Easton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Maryland
H. Sander

DATE OF BURIAL,

July 4, 1915.

ADDRESS

1710 East H.

Cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86434

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86434

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

2-CITY OF BALTIMORE (No.)

3-FULL NAME

(Residence in Baltimore: No.)

Mary Hospital
Singleton Pryor
1012 Aiguath, St.

ST.

WARD) 10

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 8 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male.

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Widowed
(Write the word.)

6-DATE OF BIRTH,

October 18, 1846
(Month) (Day) (Year)

7-AGE,

68 yrs. 8 mos. 14 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Carriage Painter

9-BIRTHPLACE.

(State or Country),

City

10-NAME OF FATHER,

Edward Pryor

11-BIRTHPLACE OF FATHER

(State or Country),

City

12-MAIDEN NAME OF MOTHER

Elizabeth Allen

13-BIRTHPLACE OF MOTHER

(State or Country),

Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Eliz. Parker

(Address)

1305 N. Bond St.

15-

JUL 4 - 1915

HARRY O. ANDREWS

Filed

191

Marital Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 2, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accident - scalds of foot & extremities - due to falling in hot bath.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY

(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. R. Hambley, M. D.
(Coroner)

July 3, 1915 (Address) 18 N. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

1012 Aiguath St.

19-PLACE OF BURIAL OR REMOVAL,

Baltimore County

DATE OF BURIAL,

July 5, 1915

20-UNDERTAKER

Henry H. H. H.

ADDRESS

1305 E. Bay St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.; *10* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1112 Central Ave.* St.; *30* yrs., *4* mos. *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

married

6-DATE OF BIRTH,

February 9th, 1885
(Month) (Day) (Year)

7-AGE,

30 yrs. *4* mos. *24* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Housework

9-BIRTHPLACE,

(State or Country),

Baltimore City Maryland

10-NAME OF FATHER,

Lawrence F. Krieger

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Mary E. Steinmann

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Mr. Aloisius Bauer

(Address).....

1112 N. Central Ave.

JUL 4 - 1915

HARRY O. ANDREWS,

Filed.....

191.....

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 3, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 14 1915, to July 3 1915,*that I saw her alive on *July 3 1915,*and that death occurred, on the date stated above, at *2:30 p.m.*

The CAUSE OF DEATH* was as follows:

Tumor of Brain.....
(Duration).....*about 3* yrs.ds.

CONTRIBUTORY (Secondary)

*Cardiac & Respiratory**Paralysis*..... (Duration).....*1* yrs.ds.(Signed).....*J. W. Kinton*.....*Chf. M. D.**July 3, 1915* (Address).....*St. Joseph's Hospital*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death - yrs. - mos. *19* ds. In the *30* yrs. *4* mos. *24* ds. State

Where was disease contracted, if not at place of death?

unknown

Former or usual residence

1112 Central Ave.

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Cemetery

DATE OF BURIAL,

July 6, 1915.

20-UNDERTAKER

Henry Storch Son

ADDRESS

1307 E. 34th St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86433

CERTIFICATE OF DEATH.

109

C86433

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Woman's Hospital* ST.: *13* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1b.)

FULL NAME *Mary J. Keller*(Residence in Baltimore: No. *765 Carver Avenue* St.: *(Left)* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-STATUS,
MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April
(Month)*21st*, *1875*
(Day) (Year)

7-AGE,

40 yrs. *2* mos. *11* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*9-BIRTHPLACE,
(State or Country),*Md. (Balt City)*

10-NAME OF FATHER,

*Amos A Ruby*11-BIRTHPLACE OF FATHER
(State or Country),*Md*

12-MAIDEN NAME OF MOTHER

*Sallie Harper*13-BIRTHPLACE OF MOTHER
(State or Country),*Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*B. Keenan, Supt. Hosp.*(Address).....*Woman's Hospital, Balt.*

15-

JUL 4 - 1915

HARRY O. ANDREWS,

Filed..... 191. *Serial 10111* *CLAY*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, *2*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 27 1915, to *July 2 1915*,that I saw him alive on *July 2 1915*,and that death occurred, on the date stated above, at *10:15 AM*

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction(Duration)..... yrs. mos. *12* ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed).....*A. P. Jones*..... M. D.*July 2 1915*. (Address).....*Woman's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *6* ds. In the State *Life* yrs. mos. ds.Where was disease contracted, if not at place of death? *Home*Former or usual residence *765 Carver Ave.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Mary's Hospital *July 4 1915*

20-UNDERTAKER

ADDRESS

Chenoweth Long Chestnut Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86437

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.; *14* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1505 Penn Ave* St.; *50* yrs., — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widowed*

6-DATE OF BIRTH,

April, *1845*
(Month) (Day) (Year)

7-AGE,

70 yrs. — mos. — ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....*None*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, *James O'Donoghue*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER *Ann O'Donoghue*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*St. Joseph's Hospital*.....(Address).....*St. Joseph's Hospital*.....

15-

JUL 4 - 1915 HARRY O. ANDREWS,
Filed..... 191.....*Marial Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, *4*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 22, 1915, to *July 4*, 1915,
that I saw her alive on *July 4*, 1915,
and that death occurred, on the date stated above, at *5 A* m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
nephritis -
hypertension
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Dehydration - Urinary
infection (Duration).....yrs.....6.....mos.....ds.
(Signed).....*J. W. V. Clift*.....M. D.
....., 191..... (Address).....*St. Joseph's Hn.*.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *12* ds. In the *50* State yrs. mos. ds.Where was disease contracted, if not at place of death? *not known*Former or usual residence *1505 Penn Ave.*

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL

July 6, 1915

20-UNDERTAKER

W. M. Gault

ADDRESS

1624 Mt. Royal

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUL 4 - 1915

HARRY O. ANDREWS,

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at C. A. M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY. (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (NO. *Maryland Penitentiary* ST. *10* WARD)

2-FULL NAME *Walter E. Belt*

(Residence in Baltimore: No. *MD Penitentiary* St.; — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN not No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

May - 5 - 1851
(Month) (Day) (Year)

7-AGE

64 yrs. *1* mos. *24* ds. or *1* day, *24* hrs. If LESS than

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer.

9-BIRTHPLACE

(State or country)

Montgomery Co. Md.

10-NAME OF FATHER

William J. Belt

11-BIRTHPLACE OF FATHER

(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Ellen Stewart

13-BIRTHPLACE OF MOTHER

(State or country)

Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

JUL 4 - 1915

Filed

191

HARRY O. A. [illegible]

Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July - 3 - 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 9 - 1915, to *July 3 - 1915*,

that I saw him alive on *July 3 - 1915*,

and that death occurred, on the date stated above, at *2 P.* m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure from Edema

Dr. J. J. [illegible] (Clinical Diagnosis)

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

Carcinoma of Stomach

(Duration) yrs. mos. ds.

(Signed) *William J. Schwartz* M. D.

July - 3 - 1915 [Address] *Maryland Penitentiary*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *2* yrs. *2* mos. *24* ds. In the *64* yrs. *1* mos. *24* ds. State

Where was disease contracted, if not at place of death?

Former or usual residence *MD Penitentiary*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laytonville Md. July 6 - 1915

20-UNDERTAKER

ADDRESS

W. J. [illegible] for [illegible]

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. 235 W. Ruston St.; 11 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME (~~Mary Virginia~~) Mina McLorris Oliver

Residence in Baltimore: No. 235 W. Ruston St.; 70 yrs., 5 mos., — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female 4-COLOR OR RACE. white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. married (Write the word.)

6-DATE OF BIRTH. Oct. 8, 1844 (Month) (Day) (Year)

7-AGE. 70 yrs., 8 mos., 25 da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. house-wife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Saul R. Reger

(Address) 1144 E. North Ave.

15-

JUL 4 - 1915

Filed 191

HARRY O. ANDREWS

Marial Permit 019

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 3, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 5 1915, to July 3 1915, that I saw her alive on July 2 1915, and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

Rheumatic Arthritis

(Duration) 30 yrs., — mos., — da.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) 8 yrs., — mos., — da.

(Signed) Wm. J. McDonald M. D.

July 3, 1915. (Address) 1309 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death — yrs., — mos., — da. In the State — yrs., — mos., — da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

London Park July 5, 1915

20-UNDERTAKER, ADDRESS.

W. J. Lickner & Son North Pa

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86441

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1311 N. Fulton avenue, St. 15 WARD)

REGISTERED No. C

2-FULL NAME Caroline Leary,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1311 N. Fulton avenue,

St. 8 yrs., 7 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed, (Write the word.)

6-DATE OF BIRTH, October 3d, 1886, (Month) (Day) (Year)

7-AGE, 88 yrs., 9 mos., 0 ds., If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, ? ? Golden,

11-BIRTHPLACE OF FATHER (State or Country), Unknown,

12-MAIDEN NAME OF MOTHER ? ? Mears,

13-BIRTHPLACE OF MOTHER (State or Country), Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Caroline Shipley, niece, (Address) 1311 N. Fulton avenue,

15- JUL 4 - 1915 HARRY O ANDREWS, Registrar, Filed

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 3d, 1915, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock, caused by an accidental fall down stairway, (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds. (Signed) Frederick Kimpel, M. D. (Coroner.) July 4, 1915 (Address) 3310 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Tondreau Park, DATE OF BURIAL, July 5, 1915

co-UNDERTAKER William Cook ADDRESS 602 E. North

C86442

15-92
REGISTER

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 701 Goble St. St.; 2 yrs., 0 mos., 0 ds.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Oct 23, 1860
(Month) (Day) (Year)

If LESS than 1 day.
....hrs. or....min.?

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

1-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE
OF FATHER
(State or Country)

12-MAIDEN NAME
OF MOTHER

**13-BIRTHPLACE
OF MOTHER
(State or Country)**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Golda L. Wisenauer Former
usual res
(Address) 701 Gold n

15- JUL 4 - 1915

HARRY O. ANDREWS
 Serial Permit Ole
 Registrar.

16-DATE OF DEATH, July 14, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1916, to July 4 1916,
that I saw her alive on July 3 1916
and that death occurred, on the date stated above, at 4 15 a. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed) _____ M. D.
7/4/1915 (Address) 117 H. Cameron

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	...	yrs. ...	mos. ...	ds. ...	In the State	...	yrs. ...	mos. ...	ds. ...
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Where was disease contracted,
if not at place of death?.....
former or
usual residence

10-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

C86443

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86443

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Bayard ST. 21 WARD)

FULL NAME

Residence in Baltimore: No. 1017 Bayard

St.; 4 yrs., 10 mos. 17 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH,

Aug. 16, 1910.
(Month) (Day) (Year)

7-AGE,

4 yrs., 10 mos., 17 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Home

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

George H. Colburn

11-BIRTHPLACE OF FATHER (State or Country),

Annapolis Md.

12-MAIDEN NAME OF MOTHER

Louisa A. Miller

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

George H. Colburn

(Address)

1017 Bayard St.

15-

FILE

JUL 4 - 1915,

HARRY O. ANDREWS,

Special Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 3, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 29, 1915, to July 3, 1915.

that I saw her alive on July 3, 1915,

and that death occurred, on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH* was as follows:

Acute Polymyelitis

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY

(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Lumsden, M. D.

July 4, 1915. (Address) 645 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Louden St. Cemetery July 5, 1915.

20-UNDERTAKER

ADDRESS

Joseph Block 1003 N. Eads

important. See instructions on back of certificate.

10. b. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86444

C86444

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 8)

2-FULL NAME

(Residence in Baltimore: No. 1214 N. Bond

ST.: 8 WARD)

REGISTERED NO. C 78

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male White

4-COLOR OR RACE

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)

Single

10-DATE OF DEATH

July

3, 1915

6-DATE OF BIRTH

April 27, 1876

7-AGE

39 yrs. 2 mos. 6 ds.

If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer
General

9-BIRTHPLACE,

(State or Country)

Baltimore

10-NAME OF FATHER

John J. McKewen

11-BIRTHPLACE OF FATHER
(State or Country)

Ireland

12-MAIDEN NAME OF MOTHER

Bridget Eagan

13-BIRTHPLACE OF MOTHER
(State or Country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie Hogarty

(Address)

158 N. Gay St.

15-JUL 4 - 1915,

CLARENCE O. ANDREWS,

Filed..... 191

Marital Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, Autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, Autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

acute cardiac dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis

(Signed) Thomas Chambers M. D.

July 4, 1915 (Address) 18 N. Franklin St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cathedral July 5, 1915

20-UNDERTAKER

H. C. Wiedefeld 914 Green Mt Ave

C86445

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (NO.

ST.,

WARD)

REGISTERED NO. C

FULL NAME

(Residence in Baltimore: No.

St.; yrs.; mos.; ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6-DATE OF BIRTH,

Jan 14, 1873
(Month) (Day) (Year)

7-AGE,

57 yrs. 4 mos. 20 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION;

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Merchant
General

9-BIRTHPLACE, (State or Country),

Md.

PARENTS.

10-NAME OF FATHER,

Oliver Cromwell

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Sarah Somerville

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Mrs. Etta A. Cromwell)
(Address) 1709 E. Fairmount Ave.

15-

JUL 5- 1915
Filed.....

RECEIVED

KRAUL

Burial Record Office

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 4, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1, 1915, to July 4, 1915,

that I saw him alive on July 4, 1915,

and that death occurred, on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

General Peritonitis - Sclerotic

Duration..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cerebral Sclerosis

(Signed) Edward P. Smith M. D.

July 4, 1915. (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death? 1709 E. Fairmount Ave

Former or usual residence 1709 E. Fairmount Ave

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

South Park Cemetery

July 5, 1915

20-UNDERTAKER

ADDRESS

H. C. Hughes 17 S. Broadway

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. 1 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and full out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX ~~Male~~ 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6-DATE OF BIRTH *April 6, 1915*
(Month) (Day) (Year)

7-AGE *2* yrs. *26* mos. *26* ds. or *1* day, *26* hrs. *26* min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
None

9-BIRTHPLACE
(State or country) *Balto. Maryland*

10-NAME OF FATHER *John C. Seifert*

11-BIRTHPLACE OF FATHER
(State or country) *Maryland*

12-MAIDEN NAME OF MOTHER *Maggie Knight*

13-BIRTHPLACE OF MOTHER
(State or country) *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *John C. Seifert*
(Address) *702 S. Luzerne St.*

15- *JUL 5 - 1915* *ROBERT J. KRAUTER,*
Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 2, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 15, 1915* to *July 2, 1915* that I saw him alive on *July 1, 1915* and that death occurred on the date stated above, at *12* m. The CAUSE OF DEATH* was as follows:

Brucella Pharyngitis
(Duration) yrs. mos. ds.

Contributory (SECONDARY) *malnutrition*
(Duration) yrs. mos. ds.
(Signed) *Wm. H. Insley* M. D.
Jul 2, 1915 (Address) *2938 E. Bldg.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *St. Carmel* DATE OF BURIAL *July 5, 1915*

20-UNDERTAKER *Gibbler & Gibbler* ADDRESS *1739 E. Eager St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hosp.* ST. *2* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1615 Shakespeare St.* St.; yrs. *5* mos. *3* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Feb. 1, 1910
(Month) (Day) (Year)

7-AGE,

5 3
yrs. mos. ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*md Balto.*

PARENTS.

10-NAME OF FATHER,

*Edward Gzykowski*11-BIRTHPLACE OF FATHER
(State or Country),*Russian Poland*

12-MAIDEN NAME OF MOTHER

*Mary Mickowski*13-BIRTHPLACE OF MOTHER
(State or Country),*Russian Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Phelps*(Address) *John Hopkins Hosp.*

15-

JUL 5 - 1915

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 4, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 2, 1915, to July 4, 1915,*that I saw her alive on *July 4, 1915,*and that death occurred, on the date stated above, at *8 45* m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion
(Duration) yrs. mos. *3* ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *G. A. Batten* M. D.*July 2, 1915* (Address) *John Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *2* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1615 Shakespeare St.*

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Holy Rosary, July 5, 1915

20-UNDERTAKER

ADDRESS

William Fialkowski, 168 Eastern Ave.

important. See instructions on back of certificate.

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86448

CERTIFICATE OF DEATH

81

C86448

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

326 W-21 St

St. 112 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Eben Moreton

Residence in Baltimore: No.

326 W-21 St

St. 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6-DATE OF BIRTH

Feb

6

1827

(Month)

(Day)

(Year)

7-AGE

88

4

mos.

27

ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

Farmer

9-BIRTHPLACE

(State or country)

Cabland Canall Co. Md.

10-NAME OF FATHER

Samuel Moreton

11-BIRTHPLACE OF FATHER

(State or country)

England

12-MAIDEN NAME OF MOTHER

Rezia Hubbard

13-BIRTHPLACE OF MOTHER

(State or country)

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E.D. Moreton

326 W-21 St

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July

3

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 2

1915

to

July 3

1915

that I saw him alive on

July 3

1915

and that death occurred, on the date stated above, at 3:30 PM

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration)

1

yrs.

mos.

ds.

Contributory (SECONDARY)

Cardiac Insufficiency

(Duration)

7

mos.

ds.

(Signed)

Rose G. Brown M.D.

July 3, 1915

(Address)

12438 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL

Cockeysville Md.

July 5, 1915

20-UNDERTAKER

W.C. Brooks Sparks

JUL 5 - 1915

Serial Permit Clerk

REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86449

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 C86449

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 Homestead ST. 9 WARD)

2-FULL NAME Amanda Martin

(Residence in Baltimore: No. 1136 Homestead St. St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and ROOM No. 12.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH Sept. 1837 (Month) (Day) (Year)

7-AGE 77 yrs. mos. ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Ind.

PARENTS 10-NAME OF FATHER Samuel Martin 11-BIRTHPLACE OF FATHER (State or country) Ind. 12-MAIDEN NAME OF MOTHER Hancy Knott 13-BIRTHPLACE OF MOTHER (State or country) Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Pruitt (Address) 1136 Homestead St.

15- JUL 5 - 1915 Filed 1915

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 7 3 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/23, 1915, to 7/2, 1915, that I saw her alive on 7/2, 1915, and that death occurred, on the date stated above, at 9 4 m. The CAUSE OF DEATH* was as follows:

Brachio pneumonia followed by left hemiplegia; natural degeneration, of no doubt several yrs. duration, complicating both. (Signed) Paralysis Henry Russell M.D. 7/4/15 (Address) West Arlington, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St. Peter's cemetery DATE OF BURIAL July 6th 1915

20-UNDER-TAKER John A. Moran ADDRESS Bank & Ham

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 S. Modern ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Theresa BlackwiczResidence in Baltimore: No. 515 S. Modern St.; 6 yrs., 6 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female4-COLOR OR RACE, White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
(Write the word.)

6-DATE OF BIRTH,

June 14, 1914
(Month) (Day) (Year)

7-AGE,

6 yrs., 21 mos., 21 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country), Baltimore Md.10-NAME OF FATHER, Joseph Blackwicz

11-BIRTHPLACE OF FATHER

(State or Country), Baltimore Md.12-MAIDEN NAME OF MOTHER Katharine Lipka

13-BIRTHPLACE OF MOTHER

(State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Blackwicz(Address) 515 S. Modern St.

15-JUL 5 - 1915

Filed....., 191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 5, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 4, 1915, to July 5, 1915,that I saw her alive on July 4, 1915,and that death occurred, on the date stated above, at 12.20 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion - Entente

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) A. F. Rus M. D.July 5, 1915. (Address) 24 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. StanislausJuly 5, 1915

20-UNDERTAKER

ADDRESS

M. J. Sadowski405 S. Ann St.

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PHYSICIANS should state AGE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74

C86431

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

IF LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER.

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. (Inquest, autopsy or inquiry.)

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D. (Coroner.)

July 4, 1915. (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER.

ADDRESS.

15-

Filed

JUL 5 - 1915

ROBERT E. BAUTER, Registrar.

London Park
R. S. Turner

July 5, 1915
1442 N. Brady

C86452 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1641 N North Ave* ST. *15* WARD)

2-FULL NAME

Clara Fells(Residence in Baltimore: No. *1641 N North Ave* St. *34* yrs. *3* mos. *15* dn.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Widow*

6-DATE OF BIRTH.

*Dec.**18**1836*

(Month)

(Day)

(Year)

7-AGE.

*48**6**15**da.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*House*

9-BIRTHPLACE.

(State or Country),

Germany

10-NAME OF FATHER.

Bernhard Schwartz

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Lillemor

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Fells*(Address) *1641 N North Ave*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*July**3**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 22**1915**1915*that I saw her alive on *July 3* *1915*and that death occurred, on the date stated above, at *3 P. m.*

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral Hemorrhage)

(Duration).....yrs.....mos.....da.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....da.

(Signed) *Joseph J. Harn* M. D.*July 4, 1915* (Address) *1641 N North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Beth Helman**July 6**1915*

20-UNDERTAKER

ADDRESS

*David Lordein**118 N North Ave*

Certificate of Death in plain form, to be filled out by the informant, is very important. See instructions on back of certificate.

15- JUL 5 - 1915

Filed

191

REGISTRAR

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. 1008 Vine St ST. 18 WARD)2-FULL NAME Alise Bray(Residence in Baltimore: No. 1008 Vine St St. 1 yrs. 4 mos. 4 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Col5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Single

6-DATE OF BIRTH

unknown, 1913
(Month) (Day) (Year)

7-AGE

1 yrs. 10 mos. — ds. If LESS than
1 day, — hrs. or — min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)None

9-BIRTHPLACE

(State or country)

md

PARENTS

10-NAME OF FATHER

John Craig

11-BIRTHPLACE OF FATHER

(State or country)

West Indies

12-MAIDEN NAME OF MOTHER

Nora Preston

13-BIRTHPLACE OF MOTHER

(State or country)

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nora Preston

(Address)

1008 Vine St

15

JUL 5 - 1915

ROBERT : KRAUTER

Burial permit clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 4, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 30, 1915, to July 4, 1915.that I saw him alive on July 3, 1915.and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(Duration) 14 yrs. — mos. — ds.Contributory
(SECONDARY)Exhaustion(Duration) 7 yrs. — mos. — ds.(Signed) Geo. E. Gropper M. D.July 4, 1915 (Address) 917 N. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carroll countyJuly 6, 1915

20-UNDERTAKER

ADDRESS

Edwards Ireland1144 S. Charles St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Union Protestant Infirmary* REGISTERED NO. C
 CITY OF BALTIMORE: (No. *1514 Division* ST.; *14* WARD) (If death occurred in a hospital or institution, give its NAME, instead of street and number and fill out No. 18.)
 2-FULL NAME *Henry H. Hubner*
 (Residence in *Baltimore* No. *Aborne ave Catonsville Md* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*
 6-DATE OF BIRTH, *July 20, 1895*
 (Month) (Day) (Year)
 7-AGE, *39* yrs. *11* mos. *16* ds. If LESS than 1 day, hrs. or min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Lawyer*
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Maryland*
 10-NAME OF FATHER, *John Hubner*
 11-BIRTHPLACE OF FATHER (State or Country), *Germany*
 12-MAIDEN NAME OF MOTHER, *Mary Harker*
 13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *John Hubner*
 (Address) *Catonsville Md*

15- JUL 5 - 1915 ROBERT . KRAUTER,
 FINE 191. *191* Permit Clerk
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 4, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 27* 1915, to *July 4* 1915, that I saw him alive on *July 5* 1915, and that death occurred, on the date stated above, at *7 a.m.*

The CAUSE OF DEATH* was as follows:

Delirium tremens
 (Duration) yrs. mos. *5* ds.
 CONTRIBUTORY (Secondary) *Broncho-Pneumonia*
 (Duration) yrs. mos. *3* ds.
 (Signed) *R. F. Kieffer* M. D.
July 9, 1915 (Address) *1514 Division ST*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
 At place of death yrs. mos. *7* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *N. P. S.*
 Former or usual residence *Catonsville, Md.*

19-PLACE OF BURIAL OR REMOVAL, *London Park Cem* DATE OF BURIAL, *July 6, 1915*
 20-UNDERTAKER *Hoffenkamp No. 6* ADDRESS *Hoffenkamp No. 6*

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

086455

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1740 E. Eager ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1740 East Eager St.; 33 yrs., 3 mos., 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 16, 1882 (Month) (Day) (Year)

7-AGE, 33 yrs., 3 mos., 17 ds. IF LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, at home

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Charles T. De Ford11-BIRTHPLACE OF FATHER (State or Country), Md12-MAIDEN NAME OF MOTHER, Fannie Davis13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Hess(Address) 1740 E. Eager St.

15-

JUL 5 - 1915 1915 ROBERT KRAUTER Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 3, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25th 1915, to July 3rd 1915, that I saw h or alive on July 2nd 1915, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia & tuberculosis

(Duration) all yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Edw. J. Storer M. D. July 4th 1915 (Address) 154 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Carmel

DATE OF BURIAL,

July 6, 1915

20-UNDERAKER

Gurkler & Gurkler

ADDRESS

1739 E. Eager

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
 CITY OF BALTIMORE: (No. *717 E. Fort*) ST. *2nd* WARD
 FULL NAME *Eleanor McNamery*
 (Residence in Baltimore: No. *717 E. Fort* and St. *48* yrs., *6* mos. *28* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write the word.*) *widow*
 6-DATE OF BIRTH, *Dec 6*, 18*66*
 (Month) (Day) (Year)
 7-AGE, *48* yrs., *6* mos. *28* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Housework.*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balto Ind.*

10-NAME OF FATHER, *Wm J. Jewell*
 11-BIRTHPLACE OF FATHER (State or Country), *Maryland*
 12-MAIDEN NAME OF MOTHER, *Elizabeth Stonaker*
 13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *Margaret Maish*
 (Address) *1718 E. Lenoir*

15- *JUL 6 - 1915*
 Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 4*, 191*5*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 16* 191*5*, to *July 4* 191*5*, that I saw her alive on *7.4* 191*5*, and that death occurred, on the date stated above, at *4 a.* m. The CAUSE OF DEATH* was as follows:

Myocarditis
 (Duration)..... yrs..... mos. *10* ds.
 CONTRIBUTORY (Secondary) *Exhaustion. Motor Paralysis.*
 (Signed) *L. J. Livingston* M. D.
7.4., 191*5*. (Address) *12th E. Fort*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
 At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?
 Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *CEDAR HILL* DATE OF BURIAL, *JUL 7 - 1915*

20-UNDERTAKER, *ARMSTRONG-DENNY CO.* ADDRESS *715 Light St*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1438 Marshall* ST. *23* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1438 Marshall* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-MARRIED, WIDOWED, OR DIVORCED, *widow* (Write the word.)6-DATE OF BIRTH, *Feb* *22*, 18*57*.
(Month) (Day) (Year)7-AGE, *58* yrs. *4* mos. *11* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Housework*.
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *AACo Md.*10-NAME OF FATHER, *Joshua Chaney*11-BIRTHPLACE OF FATHER (State or Country), *AACo Md.*12-MAIDEN NAME OF MOTHER, *Caroline Bryan*13-BIRTHPLACE OF MOTHER (State or Country), *AACo Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Whitson Son*(Address) *1438 Marshall St.*15- *ROBERT . KRAUTER,*JUL 6 - 1915. *101 permit clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, *July* *3*, 191*5*.
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *July 1* 191*5*, to *July 3* 191*5*, that I saw him alive on *July 3* 191*5*, and that death occurred, on the date stated above, at *11:25 a* m.

The CAUSE OF DEATH* was as follows:

Paralysis
apoplectic *at home*
CONTRIBUTORY *Hemiplegia*
(Secondary)
Spinal Cord
(Signed) *J. S. Livingston* M. D.
7.3, 191*5*. (Address) *102 E. Fort St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

CEDAR HILL

DATE OF BURIAL

JUL 6 - 1915

20-UNDERTAKER

ARMSTRONG-DENNY CO.

ADDRESS

715 Lig St SE

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *518 Archer* ST.; *21* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Charles Casper Gardner*(Residence in Baltimore: No. *518 Archer St* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, *single* WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *Jan.* *8*, 19*15* (Month) (Day) (Year)7-AGE, *5* *26* yrs., mos., ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work *not any* (b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Charles Henry Gardner*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Mary Anna Reinhardt*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Chas. Gardner*(Address) *518 Archer St*15- *JUL 6 - 1915* *ROBERT . KRAUTER,* *Bureau Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July* *4*, 19*15* (Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *July 3rd* 19*15* to *July 4* 19*15*, that I saw him alive on *July 4th* 19*15*, and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

*Toxemia*Duration) *3* mos. *3* ds. CONTRIBUTORY (Secondary) *Gastro Enteritis*(Signed) *G. L. Briston* M. D. *July 5*, 19*15*. (Address) *301 East Carroll St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

New Cathedral Cemetery *July 6* 19*15*

20-UNDERTAKER, ADDRESS

James Dignan & Son *1000 S. Paca St.*

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PHYSICIANS should state

C86459

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86459

CERTIFICATE OF DEATH.

28

PLACE OF DEATH

CITY OF BALTIMORE (No. *1816 Aisquith*)

ST. *9*

WARD)

REGISTERED NO. C

FULL NAME

Mary E. Gannon

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1816 Aisquith*)

St. *5* yrs., *8* mos., *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Child*

6-DATE OF BIRTH, *Oct 23rd 1914*
(Month) (Day) (Year)

7-AGE, *5* yrs., *8* mos., *12* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... *Child*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Ind*

10-NAME OF FATHER, *Walter B. Gannon*

11-BIRTHPLACE OF FATHER (State or Country), *Ind*

12-MAIDEN NAME OF MOTHER, *Loene Colley*

13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Loene M. Gannon*

(Address) *1816 Aisquith St*

15- *JUL 6 - 1915* *ROBERT KRAUTER*

Filed *191* *Serial Permit Clerk*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 4th 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*
(Inquest, au-

opsy and that said deceased came to *death*
topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (?)

(Duration) *1* yrs., *8* mos., *12* ds.

CONTRIBUTORY *Pulmonary Tuberculosis*
(Secondary)

(Duration) *1* yrs., *8* mos., *12* ds.

(Signed) *Elyah I. Russell* M. D.

(Coroner.) *July 5, 1915* (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *New Cathedral Cem.*

DATE OF BURIAL, *July 6, 1915*

20-UNDERTAKER, *William Cook*

ADDRESS, *502 E. North*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86460

C86460

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)

16-DATE OF DEATH

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUL 6 1915

ROBERT KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Articular Rheumatism

(Duration).....yrs. mos. ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs. mos. ds.

(Signed).....M. D.

July 5, 1915. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. mos. ds. In the State.....yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Forsdon Park

UNDERTAKER

William Cook

ADDRESS

502 E North

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C86461

PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *4* WARD)FULL NAME *Bettie Hall*(Residence in Baltimore: No. *640 Raking* St.; yrs. mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Colored.*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)
Married

6-DATE OF BIRTH.

Unknown, 1873
(Month) (Day) (Year)

7-AGE.

42 yrs. mos. da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).*Virginia*

10-NAME OF FATHER.

*Henry Johnson*11-BIRTHPLACE OF FATHER
(State or Country).*Virginia*

12-MAIDEN NAME OF MOTHER

*Elizabeth Johnson*13-BIRTHPLACE OF MOTHER
(State or Country).*Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Walter Owens

(Address)

235 Vine St.

15-JUL 6 - 1915

ROBERT KRAUTER

Registrar.

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HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1115 Parish*)ST. *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Ellis Lewis*(Residence in Baltimore: No. *1115 Parish*)St.; yrs. *7* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Col.

5-SINGLE,

MARRIED,

WIDOWED,

OR-DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH

*Mar.**20**1891*

(Month)

(Day)

(Year)

7-AGE,

24

yrs.

3

mos.

13

da.

If LESS than 1 day,

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Porter in Store

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Paton Lewis

11-BIRTHPLACE OF FATHER

(State or Country), *Don't know*

12-MAIDEN NAME OF MOTHER

Alice Boese

13-BIRTHPLACE OF MOTHER

(State or Country), *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alice Lewis*(Address) *1115 Parish St.*

15-

JUL 6 - 1915

Filed..... 191.....

*JOSEPH KRAUTER**Deputy Registrar*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

(Month)

3

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 25 1915, to *July 3 1915*,that I saw him alive on *July 3 1915*,and that death occurred, on the date stated above, at *6:30* m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis(Duration)..... yrs. *3* mos. da.

CONTRIBUTORY..... (Secondary)

(Duration)..... yrs. mos. da.

(Signed) *Paul Brown* M. D.*July 5 1915* (Address) *1837 Penna Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. da. In the State..... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. John**July 6 1915*

20-UNDERTAKER

R. L. Pughan

ADDRESS

221 Reson

important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

(86463)

CERTIFICATE OF DEATH

(86463)

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

219 N. Pine

ST.

WARD)

FULL NAME

Charles Edwards.

(Residence in Baltimore: No.

219 N. Pine

St. 43 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

single

6 DATE OF BIRTH

March

24

1872

(Month)

(Day)

(Year)

7 AGE

43

3

mos.

10

ds.

If LESS than

1 day, hrs.

or min. 7

8 OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

waiter

9 BIRTHPLACE

(State or country)

Baltimore, Ind.

10 NAME OF FATHER

Samuel Edwards.

11 BIRTHPLACE OF FATHER

(State or country)

Baltimore, Ind.

12 MAIDEN NAME OF MOTHER

Mary Hawkins

13 BIRTHPLACE OF MOTHER

(State or country)

Baltimore, Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chester Poland, M.D.

(Address)

2532 Edmondson Ave

15

JUL 6 - 1915

ROBERT KRAUTER,

Marital Permit Clerk

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

4

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 10, 1915, to July 4, 1915,

that I saw him alive on July 4, 1915,

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach
(not operated on)

(Duration) 1 yrs. mos. ds.

Contributory Pulmonary tuberculosis
(SECONDARY)

(Duration) 2 yrs. mos. ds.

(Signed) Chester Poland, M.D.

7-5-1915 (Address) 2532 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Auburn

July 11, 1915

20 UNDERTAKER

ADDRESS

Samuel S. Shumsky 578 N. Beale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86465

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *2804 Eversmire Terrace* ST. *13* WARD)

FULL NAME

Mary K. Kupper

(Residence in Baltimore: No. *2804 Eversmire Terrace* St. yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME in stead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*
(Write the word)

DATE OF BIRTH *Unknown*
(Month) (Day) (Year)

AGE *about 67* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country) *Italy*

NAME OF FATHER *Samuel Kupper*

BIRTHPLACE OF FATHER (State or country) *Italy*

MAIDEN NAME OF MOTHER *Louise Boulton*

BIRTHPLACE OF MOTHER (State or country) *Italy*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harry Kupper*
(Address) *2804 Eversmire Terrace*

JUL 6 - 1915

ROBERT KRAUTER
Burial Permit

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *July 4, 1915*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *May 21*, 1915, to *July 4*, 1915, that I saw him alive on *July 4*, 1915, and that death occurred, on the date stated above, at *4 a.* m. The CAUSE OF DEATH* was as follows:

Intermittent Hypertension

about 3 yrs
(Duration) yrs. mos. ds.

Contributory (SECONDARY) *Arteriosclerosis*
(Duration) *about 3 days* yrs. mos. ds.
(Signed) *Carlton M. Cook* M. D.
July 5, 1915 (Address) *1107 W. Lombard St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL *Linden Park* DATE OF BURIAL *July 6, 1915*

ENTERTAKER *W. H. H. H. H.* ADDRESS *W. H. H. H.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1605 E. Sawale* ST.: *8*)

REGISTERED No. C

FULL NAME *Anna M. Blumenauer*

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1605 E. Sawale*St.: *28* yrs., *4* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

*March**2**1887*

(Month)

(Day)

(Year)

7-AGE,

*28**1**1*

ds.

If LESS than 1 day,

hrs. or mins.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*none*9-BIRTHPLACE,
(State or Country),*Baltimore Md.*

10-NAME OF FATHER,

*Charles J. Blumenauer*11-BIRTHPLACE OF FATHER
(State or Country),*Frederick Md.*

12-MAIDEN NAME OF MOTHER

*Theresa Hubert*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Charles J. Blumenauer*(Address) *1605 E. Sawale St.*

15-

JUL 6 - 1915

ROBERT KREJCI

SPECIAL PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**3**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 1* 1915, to *July 3* 1915, that I saw him alive on *July 3* 1915, and that death occurred, on the date stated above, at *10:30 P.M.*

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis(Duration) *2* yrs. *5* mos. *15* ds.CONTRIBUTORY
(Secondary)*Anaemia*(Duration) *2* yrs. *5* mos. *15* ds.(Signed) *John J. B. M. D.**July 5, 1915. (Address) 2844 St. Paul St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Holy Redeemer Cemetery**July 7, 1915*

20-UNDERTAKER

ADDRESS

*Henry Hobbs Son**1301 E. Eager St.*

important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

FULL NAME

(Residence in Baltimore: No.

St.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

DATE OF BIRTH

April

6

1915

AGE

3

mos.

ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

BIRTHPLACE

(State or country)

Balto Md.

NAME OF FATHER

John C. Seifert

BIRTHPLACE OF FATHER

Balto Md.

MAIDEN NAME OF MOTHER

Maggie Knight

BIRTHPLACE OF MOTHER

Balto Md.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John C. Seifert

(Address)

702 S. Luzerne St

FILED

JUL 6 - 1915

ROBERT KRAUTER

Official Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

July

6

1915

I HEREBY CERTIFY. That I attended deceased from

July 1, 1915, to July 6, 1915

that I saw him alive on July 5, 1915

and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Branchio Pneumonia

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

4 ds

(Signed)

John C. Seifert

(Address) 295 E. Canton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

PLACE OF BURIAL OR REMOVAL

Mt. Carmel cem.

DATE OF BURIAL

July 7, 1915

UNDERTAKER

Zickler & Zickler

ADDRESS

1739 E. Eager St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1901 BooneST.; 9 WARD)REGISTERED NO. C 67th 86468

2-FULL NAME

(Residence in Baltimore: No. 1901 Boone

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Married

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Sept 7, 1852, 1
(Month) (Day) (Year)

7-AGE,

62 yrs., 9 mos., 27 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country), York Co., Pa10-NAME OF FATHER, David Hooke11-BIRTHPLACE OF FATHER
(State or Country), York Co., Pa12-MAIDEN NAME OF MOTHER Caroline Whitman13-BIRTHPLACE OF MOTHER
(State or Country), Manchester York Co. Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin Leon(Address) 1901 Boone St

15-

JUL 6 - 1915

Filed

191

BIRTH CERTIFICATE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 4, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 20, 1915 to July 4, 1915that I saw her alive on July 30, 1915and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Senile Dementia.....
(Duration) 9 yrs., mos., ds.CONTRIBUTORY
(Secondary) Paralysis.....
(Duration) 2 yrs., mos., ds.(Signed) Reginald T. Loney, M. D.July 4, 1915 (Address) 714 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

July 6, 1915

20-UNDERTAKER

Henry W. Means & Son

ADDRESS

80571, Calvert St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86469

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 E Lombard ST.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2201 E Lombard St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH,

March 22, 1868
(Month) (Day) (Year)

7-AGE,

47 yrs., 5 mos., 12 ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

PARENTS.

10-NAME OF FATHER,

Bernard Kepper

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

Catherine Kratz

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia Kepper(Address) 2201 E Lombard St.

15-JUL 6 - 1915,

ROBERT KNAUTH,

Filed....., 191.....

Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 25th, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 1st 1915, to July 25th 1915, that I saw him alive on July 2nd 1915, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
he was at State Sanatorium for
6 mos. S. P. duration of disease
probably over (Duration) 1 yrs., mos., ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs., mos., ds.

(Signed) R. T. Hardin M. D.July 7, 1915. (Address) 1912 Bank St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs., mos., ds. In the State..... yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mt Carmel

DATE OF BURIAL,

July 7, 1915

20-UNDERTAKER

H. Sanders & Sons

ADDRESS

1710 Fleet St

important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PHYSICIANS should

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
..... yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on 1915, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed),

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

JUL 6 - 1915
Filed 191

ROBERT KRAUTER
Bureau Permit Clerk
REGISTRAR

Holy Trinity
1710 E. Pratt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *Mercy Hospital* ST. *24* WARD)

FULL NAME

(Residence in Baltimore: No. *1529 Burroughs St*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

5 yrs. *2* mos. *19* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Child

6-DATE OF BIRTH.

Apr. (Month)

23 (Day)

1910 (Year)

7-AGE,

5 yrs.

2 mos.

19 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9-BIRTHPLACE.

(State or Country).

Russian Poland

10-NAME OF FATHER.

Wladyslaw Bialik

11-BIRTHPLACE OF FATHER.

(State or Country).

Russian Poland

12-MAIDEN NAME OF MOTHER.

Marg Sabol

13-BIRTHPLACE OF MOTHER.

(State or Country).

Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Bialik (Mother)

(Address)

1424 Towson St

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July (Month)

4 (Day)

1913 (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

accident. Burns of Body
clothing caught after fire 9/12
lighting fire. checked with matches
(Duration) ... yrs. ... mos. *5* ds.

CONTRIBUTORY (Secondary)

acute nephritis
(Duration) ... yrs. ... mos. ... ds.

(Signed)

Thos. B. Chambers M. D.
(Coroner.)

July 5, 191*3*. (Address) *18 N. Franklin St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. *25* ds. In the *4* State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

1529 Burroughs St

Former or usual residence *1529 Burroughs St*

19-PLACE OF BURIAL OR REMOVAL.

Holy Rosary

DATE OF BURIAL.

July 6 19*13*

UNDERTAKER

William Trachowski

ADDRESS

1618 Eastern Ave.

15-

JUL 6 - 1915

ROBERT KRAMER,

1913

C-86472

HEALTH DEPARTMENT—CITY OF BALTIMORE

C-86472

CERTIFICATE OF DEATH.

* 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *J. H. Hospital* St.; *7* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *3707 Mt Pleasant Ave* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

female

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

6-DATE OF BIRTH.

May 3

(Month)

(Day)

1915
(Year)

7-AGE,

2 yrs. *2* mos. *3* ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Md.*

PARENTS.

10-NAME OF FATHER, *Carl Guinan*11-BIRTHPLACE OF FATHER (State or Country), *Pa.*12-MAIDEN NAME OF MOTHER *Marion Buchanan*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Grace M. Rose*(Address) *J. H. Hospital*

15-

*JUL 6 1915**ROBERT*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 5, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 25* 191*5*, to *July 5*, 191*5*, that I saw h. *alive* on *July 5*, 191*5*, and that death occurred, on the date stated above, at *11:45* A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis General Military
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

U. S. Army
(Duration) yrs. mos. ds.(Signed) *G. A. B...* M. D.
July 5, 191*5*. (Address) *J. H. Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the *2* yrs. *2* mos. *3* ds. State *2* yrs. *2* mos. *3* ds.Where was disease contracted, if not at place of death? *3707 Mt Pleasant Ave*Former or usual residence *3707 Mt Pleasant Ave*

19-PLACE OF BURIAL OR REMOVAL,

Schwartz Cem

DATE OF BURIAL

July 7, 1915

20-UNDERTAKER

John Hennig & Co

ADDRESS

2008 Alameda

GROUP OF DEATHS IN plain text, as that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86473 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86473

1. PLACE OF DEATH

CITY OF BALTIMORE (No. *1525 Light*)

2. FULL NAME

(Residence in Baltimore: No. *1525 Light*)

Harry Schmidt

ST. *24* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

— *life* — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

Oct 11, 1883
(Month) (Day) (Year)

7. AGE

31 yrs. *8* mos. *22* ds. If LESS than 1 day, — hrs. or — min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Harness-maker at home

9. BIRTHPLACE
(State or country)

Balto., Md.

10. NAME OF FATHER

John Schmidt

11. BIRTHPLACE OF FATHER
(State or country)

Germany

12. MAIDEN NAME OF MOTHER

Victoria Gies

13. BIRTHPLACE OF MOTHER
(State or country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

George Schmidt
1525 Light St

15.

JUL 6 - 1915 *ROBERT K. KRAUSE* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 3 — , *1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March* — , 1915, to *July 3* — , 1915, that I saw him alive on *July 2* — , 1915, and that death occurred, on the date stated above, at *3 p.* m. The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Contributory (SECONDARY) *Sub Acute Nephritis*
(Duration) — yrs. — mos. — ds.
(Signed) *Imp. C. Brown* M. D.
July 3, 1915 (Address) *125 S. B. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Loudon Park Cemetery

DATE OF BURIAL

July 6, 1915

20. UNDERTAKER

H. J. W. Flynn

ADDRESS

1425 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE: ~~NO~~

2-FULL NAME

Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St.: 77 yrs., 3 mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE.

5-SINGLE,
MARRIED, *See*
WIDOWED,
OR DIVORCED,
(Write the word.)

C-DATE OF BIRTH.

Feb 2, 1875
(Month) (Day) (Year)

7-AGE.

40 yrs. 5 mos. 1 da.

It LESS than 1 day.

...hrs. or....min.?

3- OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER

11-BIRTHPLACE
OF FATHER
(State or Country).

12-MAIDEN NAME
OF MOTHER

**13-BIRTHPLACE
OF MOTHER
(State or Country).**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

18-

ROBERT KRAUTER.

FILED

1972-1973 Form 1041

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17. I HEREBY CERTIFY, That I attended deceased from June 20 1915, to July 4 1915, that I saw him alive on July 4 1915, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	hrs.	mos.	ds.	In the State	hrs.	mos.	ds.
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Where was disease contracted,
if not at place of death?

Former or
usual residence

10-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *4* WARD)2. FULL NAME *William Jones*Residence in Baltimore: No. *No Home - Baltimore Md.* St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *male* 4-COLOR OR RACE *Black* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Widowed*
(Write the word.)6-DATE OF BIRTH, *Dec 25 1884*
(Month) (Day) (Year)7-AGE *30* yrs. *6* mos. *7* ds. If LESS than 1 day, hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Sailor*
(b) General nature of industry, business, or establishment in which employed (or employer) 9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *Wm Jones*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER *Hattie Wilson*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Record Mercy Hosp*(Address) *Cabot St*

15-

JUL 6 - 1915

1915

*JOHNS**121 FORT ST. BALTIMORE*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 2 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 26 1915*, to *July 2 1915*, that I saw him alive on *July 2 1915* and that death occurred on the date stated above, at *1950* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) *Don't know* yrs. mos. ds.CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.(Signed) *Edward J. Smith* M. D.
July 3 1915 (Address) *Mercy Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *6* mos. ds. In the *Life* State yrs. mos. ds.Where was disease contracted, if not at place of death? *Don't know*Former or usual residence *Don't know*19-PLACE OF BURIAL OR REMOVAL, *HOPKINS HOSPITAL*DATE OF BURIAL, *JUL 6 - 1915*

20-UNDERTAKER

Commissioner Health.

ADDRESS

Per. Wm. E. WOODALL

FOR ANATOMICAL PURPOSES.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. *117 S. Liberty* ST.;..... WARD)2—FULL NAME *Mary A. Brannin*(Residence in Baltimore: No. *117 S. Liberty* St. *Life* yrs., .. mos. .. ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3—SEX, *Female*4—COLOR OR RACE, *White*5—SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)6—DATE OF BIRTH, *May 14th*, *1879*

(Month)

(Day)

(Year)

7—AGE, *36**1* yrs. *22* mos. .. ds.

If LESS than 1 day,

....hrs. or....min.?

8—OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9—BIRTHPLACE, (State or Country), *Balto. Md.*10—NAME OF FATHER, *John Brannin*11—BIRTHPLACE OF FATHER (State or Country), *Ireland*12—MAIDEN NAME OF MOTHER *Catherine McRostey*13—BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14—THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *Thos. Brannin*(Address)..... *301 N. Monroe St.*

15—

Filed *JUL 6 - 1915*

1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16—DATE OF DEATH, *July 5*, *1915*

(Month)

(Day)

(Year)

17— I HEREBY CERTIFY, That I attended deceased from *June 12* 1915, to *July 5* 1915, that I saw her alive on *July 4* 1915, and that death occurred, on the date stated above, at *7 A* m.

The CAUSE OF DEATH* was as follows:

Chronic Indurated Glands

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)..... *Arterial Hypertension*

(Duration)..... yrs. mos. ds.

(Signed)..... *Chas. B. Williams, M. D.**July 6*, 1915 (Address)..... *412 Cathedral St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18—LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19—PLACE OF BURIAL OR REMOVAL, *New Cathedral*DATE OF BURIAL, *July 8*, 191520—UNDERTAKER *Jas. Wignaut Son*ADDRESS *1000 N. Yaca*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86477

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86477

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. **1646 E Fort Ave**

ST.: **24** WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME **John William Sontag**

Residence in Baltimore: No. **1646 E Fort Ave**

St. **28** yrs., **6** mos. **4** ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, **Male** 4-COLOR OR RACE, **White** 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, **Single** (Write the word)

6-DATE OF BIRTH, **Jan 1, 1887** (Month) (Day) (Year)

7-AGE, **28** yrs., **6** mos., **4** ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, **Gen Baker** (b) General nature of industry, business, or establishment in which employed (or employer), **Bakery**

9-BIRTHPLACE, (State or Country) **Baltimore Md**

10-NAME OF FATHER **William Sontag**

11-BIRTHPLACE OF FATHER (State or Country) **Germany**

12-MAIDEN NAME OF MOTHER **Mary Harries**

13-BIRTHPLACE OF MOTHER (State or Country) **Germany**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mary Sontag**

(Address) **Rose near Bowell Ave**

15- **JUL 6 - 1915** **HARRY O. ANDREWS,**

Registrar.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH **July 5, 1915** (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an **Inquiry** (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said **Inquiry** (Inquest, autopsy or inquiry.) and that said deceased came to **his death** on the day stated above.

The CAUSE OF DEATH* was as follows:

Dysentary Chronic Found in bed at **6 P.M.** (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) **Exhaustion** (Duration) ... yrs. ... mos. ... ds. (Signed) **Edw. G. Smith** M. D. (Coroner.)

July 6, 1915 (Address) **517 Scott St**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL **Schwartz Co.** DATE OF BURIAL **July 8, 1915**

20-UNDERTAKER **Lilly & Ziehl** ADDRESS **403 S. Wolfes**

C86478

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86478

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1020 Mc Donogh* ST.; *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Alice R. Dean*(Residence in Baltimore: No. *1020 Mc Donogh* St.; yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *Single*
 6-DATE OF BIRTH, *Feb 24, 1915*
 (Month) (Day) (Year)
 7-AGE, *4* yrs. *11* mos. *11* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Balto.*10-NAME OF FATHER, *Ellis K. Dean*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER *Mary G. Dorey*13-BIRTHPLACE OF MOTHER (State or Country), *Balto.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary G. Dean*(Address) *1020 Mc Donogh*

15-

JUL 6 - 1915 HARRY O. ANDREWS,
 Filed, 191. *1020 Mc Donogh* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 5, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 4* 191, to *July 5* 1915, that I saw him alive on *July 5* 1915, and that death occurred, on the date stated above, at *1045 P.* m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(Duration) yrs. mos. ds. *3*CONTRIBUTORY *Contribution*
 (Secondary)(Duration) yrs. mos. ds. *3*(Signed) *Walter H. White* M. D.*July 6, 1915* (Address) *1101 Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore County* DATE OF BURIAL, *July 7, 1915*20-UNDERTAKER *Junkler & Junkler* ADDRESS *1739 E. E. Ager*

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. _____)

2-FULL NAME

(Residence in Baltimore: No. _____)

REGISTERED NO. C. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE

Married

WIDOWED

OR DIVORCED.

(Write the word.)

6-DATE OF BIRTH

November 20th, 1892

(Month)

(Day)

(Year)

7-AGE.

22 yrs. 7 mos. 14 ds.

If LESS than 1 day,

...hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country)

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER.

(State or Country)

12-NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER.

(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed JUL 6 1915

HARRY O. ANDERSON

1st DEPT. CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 5th, 1915.

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

June 24th, 1915, to July 4th, 1915.that I saw him alive on July 4th, 1915.

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Appendicitis

Perforation

(Duration) yrs. mos. ds.

General Peritonitis

(Duration) yrs. mos. ds.

(Signed) H. A. May Jr. M. D.

July 5th, 1915. (Address) 1021 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Redeemer

July 8th, 1915.

20-UNDERTAKER

ADDRESS

Geo M. Fink

844 N. Wolfe

Cause of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86480

1. PLACE OF DEATH

CITY OF BALTIMORE (No.

2. FULL NAME

(Residence in Baltimore: No.

151
REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and the cert. No. 18.)

Str. yrs. mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH

7. AGE

If LESS than

1 day, hrs.

or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSE, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

JUL 6 - 1915

Filed

, 191

HARRY O. ANDREWS,
Registrar

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST. 24 WARD

REGISTERED NO. C

FULL NAME

Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the words)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Serial Permit 019

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 4:30 AM.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *130 S. Mount* ST. *19* WARD)

2-FULL NAME

Samuel Wright

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 18.)

(Residence in Baltimore: No. *130 S. Mount St.*

65 yrs. *6* mos. *5* da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

white

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

June

10

1890

7-AGE

75

0

24

ds.

or

min?

If LESS than

1 day, hrs.

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

retired tuna cotta
worker

9-BIRTHPLACE

(State or country)

Ireland in Balto & yrs

10-NAME OF FATHER

Sam'l Wright

11-BIRTHPLACE OF FATHER

(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Johanna French

13-BIRTHPLACE OF MOTHER

(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Wright

(Address)

130 S. Mount St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July

4

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 7, 1915, to, *July 4*, 1915,

that I saw him alive on *July 4*, 1915,

and that death occurred, on the date stated above, at *6:30* m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis
& age.

Contributory (SECONDARY)

about

(Duration)

yrs.

mos.

ds.

(Duration)

yrs.

mos.

ds.

(Signed)

July 6, 1915 [Address] *1002 W. Lanvale*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place

of death

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Frederick St. Cem

July 7, 1915

20-UNDERTAKER

ADDRESS

Joseph B. Cook

1003 1/2 Balto

15-

JUL 6 - 1915

HARRY O. ANDREWS,

Registrar

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1018 W. Baltimore

ST. 18 WARD)

2-FULL NAME Anton Bindseil

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1018 W. Baltimore

St. 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widowed
6-DATE OF BIRTH September 28, 1846 (Month) (Day) (Year)		
7-AGE 68 yrs. 10 mos. 8 ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Chemist & Ice Cream manufacturer		
9-BIRTHPLACE (State or country) Germany.		
PARENTS	10-NAME OF FATHER Henry Ernst Bindseil	
	11-BIRTHPLACE OF FATHER (State or country) Prussia	
	12-MAIDEN NAME OF MOTHER Unknown	
	13-BIRTHPLACE OF MOTHER (State or country) Prussia	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anton Bindseil
(Address) 1018 W. Balto. St.

15.

Filed JUL 6 - 1915 HARRY O. ANDERSON, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
July 6, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1915, to July 6, 1915, that I saw him alive on July 5, 1915, and that death occurred, on the date stated above, at 9 p. m. The CAUSE OF DEATH* was as follows:

Pulmonary Oedema & Cardiac dilatation

(Duration) About 1 yrs. 1 mos. ds

Contributory Chronic Hypertension (SECONDARY)

(Duration) 2 or 3 yrs. mos. ds.

(Signed) M. B. Anderson M. D.

July 6, 1915 (Address) 626 N. Gilman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Linden St.

July 8, 1915

20-UNDERTAKER

ADDRESS

Joseph B. Cook

1003 W. Balto. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *706 4 Port* ST. *7* WARD)

2-FULL NAME

(Residence in Baltimore: No. *706 4 Port* St.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Married

6-DATE OF BIRTH,

November 16, 1871
(Month) (Day) (Year)

7-AGE,

43 yrs. *7* mos. *19* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Black Smith*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),*Md*

PARENTS.

10-NAME OF FATHER,

*Frederick Ochoe*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Mary C. Dickenson*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Barbara C. A. Ochoe*(Address) *706 4 Port St*

15-

JUL 6 - 1915

Filed.....

191.....

HARRY O. ANDERSON

Mort. Permit 013

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 5, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 22 1915, to July 5 1915,*that I saw him alive on *July 4 1915*and that death occurred, on the date stated above, at *4:50* m.

The CAUSE OF DEATH* was as follows:

Tumor of
Brain
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *A. Ochoe* M. D.*July 6, 1915* (Address) *2600 E. Pratt St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

July 6, 1915

20-UNDERTAKER

Christian Miller *2334 Jefferson St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 PLACE OF DEATH
CITY OF BALTIMORE: (No. 720 S. Bond ST. 3 WARD) REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2 FULL NAME Henry Yankowski
(Residence in Baltimore: No. 720 S. Bond St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single
6-DATE OF BIRTH, Sept. 3rd, 1914.
(Month) (Day) (Year)
7-AGE, 10 yrs., 3 mos., ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto City Md.

PARENTS.
10-NAME OF FATHER, Walter Yankowski
11-BIRTHPLACE OF FATHER (State or Country), Russia
12-MAIDEN NAME OF MOTHER, Helen Smith
13-BIRTHPLACE OF MOTHER (State or Country), New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Walter Yankowski
(Address) 720 S. Bond St.

15- JUL 6 - 1915
Fees 191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 6th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 29 1915, to July 6th 1915, that I saw her alive on July 6th 1915, and that death occurred, on the date stated above, at 10⁰⁰ a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis
(Duration) 8 yrs., mos., ds.

CONTRIBUTORY (Secondary) Exhaustion
(Duration) 3 yrs., mos., ds.

(Signed) Harry H. Wembarger M. D.
July 6 1915. (Address) 724 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cem. DATE OF BURIAL, July 6, 1915

20-UNDERTAKER Wander Sons ADDRESS 100 Fleet St.

STATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 130 C86487

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Church Home and Infirmary St.; 6

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Ella M Cleveland

(Residence in Baltimore: No.

Glen Ave., Md.

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

3 26, 1882
(Month) (Day) (Year)

7-AGE,

33 yrs. 3 mos. 11 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Cenia.

10-NAME OF FATHER,

Jacob X Baker

11-BIRTHPLACE OF FATHER (State or Country),

Cenia

12-MAIDEN NAME OF MOTHER

Jane E Dillman

13-BIRTHPLACE OF MOTHER (State or Country),

Cenia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Ruben J Cleveland

(Address).

Glen Ave. Md.

15-

JUL 7 - 1915

ROBERT KRAUTER

Filed

191

181 1st St. Baltimore

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 27, 1915, to July 7, 1915,

that I saw her alive on July 7, 1915,

and that death occurred, on the date stated above, at 5:07 a.m.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

(Duration) 3 yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary)

Septic (Duration) 3 yrs. 3 mos. 3 ds.

(Signed) R. J. Stair, M. D.

Resident in Baltimore, Md. (Address) Church Home and Infirmary, St. 6, Baltimore, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 10 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Albany New York July 9, 1915

20-UNDERTAKER

Frederick L. Lusk & Sons Baltimore Md.

DATE OF BURIAL.

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86483

CERTIFICATE OF DEATH.

REGISTERED NO. C

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Home & Refinery ST. 17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME

(Residence in Baltimore: No. *734 George st* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX.

Female

4. COLOR OR RACE.

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6. DATE OF BIRTH.

*Oct**4*, 18*71*

(Month)

(Day)

(Year)

7. AGE.

43 yrs. *9* mos. *1* ds.

If LESS than 1 day, ... hrs. or ... min.?

8. OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

School teacher
Public

9. BIRTHPLACE, (State or Country).

Baltimore, Md.

10. NAME OF FATHER.

William Hammerer (deceased)

11. BIRTHPLACE OF FATHER (State or Country).

Baltimore, Md.

12. MAIDEN NAME OF MOTHER.

Emma L. Stivers (deceased)

13. BIRTHPLACE OF MOTHER (State or Country).

Baltimore, Md.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *W. H. Hammerer*(Address) *515 N. Arlington St.*

JUL 7 - 1915

Filed..... 191.....

REPORT . KRAUTER,

Baptist Church

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH.

July, 191*5*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 1*, 191*5*, to *July 5*, 191*5*, that I saw her alive on *July 5*, 191*5*, and that death occurred, on the date stated above, at *3:10 P. m.*

The CAUSE OF DEATH* was as follows:

Intestinal obstruction
Complicated by Shingles (Post-herpetic)
*July 7, 1915*Multiple (Duration)..... yrs. mos. ds.
CONTRIBUTORY (Secondary) *Myocardial infarction*

(Duration)..... yrs. mos. ds.

(Signed) *Wm. H. Hammerer, M. D.**July 5*, 191*5*. (Address) *Church Home & Refinery*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ☒ yrs. mos. *5* ds. State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *734 George St.*

19. PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

London Park Cem. *July 7*, 191*5*

20. UNDERTAKER.

ADDRESS

Stewart & Mowbray *108 W. North*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86489

REGISTERED NO. C

CITY OF BALTIMORE; (NO. 200-244114 ST. 1 WARD)

2-FULL NAME 1. YANEZ, Y. J. J.

Residence in Baltimore: No. 2000 Riverside Drive St.: 10 yrs., 0 mos., 0 da.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

MEDICAL CERTIFICATE OF DEATH.

2-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 2, 1882
(Month) (Day) (Year)

7-AGE, 33 yrs. 7 mos. 3 da. ... hrs. or ... min. ...

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....*Fireman*
(b) General nature of industry, business, or establishment in which employed (or employer).....*City and County of*

9-BIRTHPLACE,
(State or Country), *Ill*

10-NAME OF FATHER. 133 135161

11-BIRTHPLACE
OF FATHER
(State or Country).

12-MAIDEN NAME
OF MOTHER

13-BIRTHPLACE
OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) 7111 1st Ave. S.W. Seattle, Wash.

15- JUL 7 - 1915
FILED..... 191..... REGISTRAR.

16-DATE OF DEATH, July 5, 1912.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1913, to July 1913 that I saw him alive on July 4 1913 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY.....
(Secondary)

..... (Duration) yrs. mos.

(Signed) James L. Long M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. da. In the State..... yrs. mos. da.

Where was disease contracted,
if not at place of death?

Formal or dual residence

<u>10-PLACE OF BURIAL OR REMOVAL.</u>	<u>DATE OF BURIAL</u>
Crematorium New York City	Aug 8, 1967

191

10-UNDERTAKER	ADDRESS
---------------	---------

624

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Dundas Ave St.; 10 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marion H. Baker(Residence in Baltimore: No. 2500 Dundas Ave St.; 10 yrs., 10 mos., 10 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male4-COLOR OR RACE. White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH. Dec 2, 1887

(Month)

(Day)

(Year)

7-AGE. 33 yrs., 7 mos., 3 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Fireman(b) General nature of industry, business, or establishment in which employed (or employer). City Fire Dept.9-BIRTHPLACE, (State or Country), Maryland10-NAME OF FATHER, Mr. Baker11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER Wollie Payne13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Marion Baker(Address) 2500 Dundas Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 5, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 1915, to July 5, 1915; that I saw him alive on July 4, 1915, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Signed) Chas. J. Lloyd M. D. July 5, 1915, (Address) 2505 Dundas Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green ParkDATE OF BURIAL, July 7, 191520-UNDERTAKER W. M. GaltADDRESS 1624 Mt. Vernon Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1731 Penna St. 14 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1731 Penna St. yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

Dec 3, 1910 (Month) (Day) (Year)

7-AGE

4 yrs. 6 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Child

9-BIRTHPLACE (State or country)

Balt Md

PARENTS

10-NAME OF FATHER

Louis Hackerman

11-BIRTHPLACE OF FATHER (State or country)

Russia

12-MAIDEN NAME OF MOTHER

Leah Lipshitz

13-BIRTHPLACE OF MOTHER (State or country)

Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J Lewis 1419-E. Balt St

15-

JUL 7 - 1915

ROBERT A. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 7, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 2, 1912, to July 7, 1915, that I saw him alive on July 6, 1915, and that death occurred, on the date stated above, at 5 a. m. The CAUSE OF DEATH* was as follows:

Chronic P.O.V. Encephalitis

Contributory (SECONDARY)

Ordinary of Sings (Duration) 3 yrs. mos. ds.

(Signed)

Jose L. Hirsch M. D. (Duration) 4 yrs. mos. ds. (Address) 1816 Linden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Heavenly Temple

7/7, 1915

20-UNDERTAKER

ADDRESS

Jack Lewis

1419 E. Balt

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86491

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *30 Albemarle* ST.; *3rd* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Frank Zaccari(Residence in Baltimore: No. *30 Albemarle* St.;yrs. mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

July 3rd, 1915
(Month) (Day) (Year)

7-AGE,

4 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*none*9-BIRTHPLACE,
(State or Country),*Baltimore Md.*

10-NAME OF FATHER,

*Rosario Zaccari*11-BIRTHPLACE OF FATHER
(State or Country),*Italy*

12-MAIDEN NAME OF MOTHER

*Angelina Cicero*13-BIRTHPLACE OF MOTHER
(State or Country),*Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Rosario Zaccari

(Address)

30 S. Albemarle St.

15-

JUL 7 - 1915

ROBERT KNAUSE

Official Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 6, 1915, to July 7, 1915,*that I saw him alive on *July 7, 1915,*and that death occurred, on the date stated above, at *3.30 a.m.*

The CAUSE OF DEATH* was as follows:

Asthma(Duration) yrs. mos. ds. *3* ds.CONTRIBUTORY
(Secondary)*Infection of umbilicus*(Duration) yrs. mos. ds. *4* ds.(Signed) *R. Palmisano* M.D.*July 7, 1915.* (Address) *316 S. Euter St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Vincent's Am.

DATE OF BURIAL,

July 7th, 1915

20-UNDERTAKER

Tilly and Jiles

ADDRESS

403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86492

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86492

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1102 Thompson St.* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1102 Thompson St.*)St. *25* yrs., mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

unknown
(Month) (Day) (Year)

7-AGE

about 53
yrs. - mos. - ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Fruit Dealer*9-BIRTHPLACE,
(State or Country),*Italy*

10-NAME OF FATHER

*Jos. Ottaviano*11-BIRTHPLACE OF FATHER
(State or Country),*Italy*

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jos. Ottaviano

(Address)

Grovers Md.

15-

ROBERT . KRAUTER

JUL 7 - 1915

BALTIMORE PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 5, 191*5*.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

July 1, 191*5*, to *July 5*, 191*5*.that I saw him alive on *July 5*, 191*5*.and that death occurred, on the date stated above, at *4 30* P.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Ceu

DATE OF BURIAL,

July 8, 191*5*

20-UNDERTAKER

E. F. Walker

ADDRESS

723 W. Lafayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

1915, to 1915,

that I saw him alive on 1915,

and that death occurred, on the date stated above, at 12⁰⁰ P.M.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

July 5, 1915 (Address) 1616 Lombard Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Congenital

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

COLLEGE OF P. & S.

20-UNDERTAKER

Commissioner Health.

FOR ANATOMICAL PURPOSES

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15-

JUL 7 - 1915

ROBERT J. KRAUTER

Filed 1915

Registrar.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 10 E. Lexington street, ST.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Dorsey,

(Residence in Baltimore: No. 10 E. Lexington street,

St.; yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, June 21st, 1915, (Month) (Day) (Year)

7-AGE, 0 yrs., 0 mos., 14 ds., If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Thomas Dorsey,

11-BIRTHPLACE OF FATHER, Maryland, (State or Country).

12-MAIDEN NAME OF MOTHER, Lizzie Simms,

13-BIRTHPLACE OF MOTHER, Maryland, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Dorsey, mother,

(Address) 10 E. Lexington street.

15- JUL 7 - 1915, ROBERT KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 5th, 1915, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry, and that said deceased came to death on the day stated above, topsy or inquiry.)

The CAUSE OF DEATH* was as follows: Asphyxia- caused by accidentally falling from a couch with the face buried in apparel, (Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary) (Duration) yrs., mos., ds. (Signed) J. Andrew K. Hempel, M. D. (Coroner.) July 5th 1915. (Address) 3310 W. North av..

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL, DATE OF BURIAL, JUL 6 - 1915.

20-UNDERTAKER, COMMUNION, ADDRESS

FOR ANATOMICAL PURPOSES.

C86495

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86495

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *836 W Lexington* ST. *18* WARD)2-FULL NAME *Infant of Joseph & Edyth Kuman*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *836 W Lexington* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH *July 7, 1915*
(Month) (Day) (Year)7-AGE If LESS than
1 day, 1 hr.,
1 day, 1 hr.,
yrs. mos. ds. or min.?8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
*Infant*9-BIRTHPLACE
(State or country) *Baltimore Md*10-NAME OF FATHER *Joseph E. Kuman*11-BIRTHPLACE OF FATHER
(State or country) *Baltimore Md*12-MAIDEN NAME OF MOTHER *Edyth P. Long*13-BIRTHPLACE OF MOTHER
(State or country) *Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. E. Kuman*
(Address) *836 W Lexington*15-
JUL 7 - 1915
ROBERT K. PAUL
SPECIAL PERMIT CLERK
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 7, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
July 7, 1915 to *July 7, 1915*,
that I saw her alive on *July 7, 1915*
and that death occurred, on the date stated above, at *2:30 a* m.

The CAUSE OF DEATH* was as follows:

Cranial Compression due to obstructive birth
(Duration) yrs. mos. ds. *1 hour*Contributory (SECONDARY)
(Duration) yrs. mos. ds.
(Signed) *Joseph E. Kuman* M. D.
July 7, 1915 (Address) *1520 Hollins*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
New Cathedral Cemetery *July 7, 1915*20-UNDERTAKER ADDRESS
John J. Fidd *1200 W. Lombard St.*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

086496

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Cumbeiland Place ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Henry Wilson(Residence in Baltimore: No. 703 Cumbeiland Place St.; 12 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH

March 5th, 1877
(Month) (Day) (Year)

7-AGE

38 yrs., 3 mos., 29 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Stereographer
Cumbeiland

9-BIRTHPLACE, (State or Country),

Norfolk, Va.

10-NAME OF FATHER,

Lefus Wilson

11-BIRTHPLACE OF FATHER (State or Country),

Norfolk, Va.

12-MAIDEN NAME OF MOTHER

Annie Owens

13-BIRTHPLACE OF MOTHER (State or Country),

Norfolk, Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Heath Wilson(Address) 703 Cumbeiland Place

15-

JUL 7 - 1915

Filed.....

191.....

REGIST. CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 4th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 2nd 1915, to July 3rd 1915, that I saw him alive on July 3rd 1915, and that death occurred, on the date stated above, at 9:30 P.m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis..... (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Lobar Pneumonia..... (Duration) yrs. mos. 7 ds.(Signed) William J. Sullivan, M.D.
July 5th 1915 (Address) 11201 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Auburn

DATE OF BURIAL,

July 7, 1915

20-UNDERTAKER

James H. Dennis

ADDRESS

1308 Ruston

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86497

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86497

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

906 Sarah Ann

ST. 18

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME

John Pickering

(Residence in Baltimore: No.

923 W. Paratoga

St. 57

yrs.

mos.

ds)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX,

male

4. COLOR OR RACE,

white

5. SINGLE,
MARRIED, widower
WIDOWED,
OR DIVORCED,
(Write the word.)

6. DATE OF BIRTH,

July 12

1857

(Month)

(Day)

(Year)

7. AGE,

57

11

23

If LESS than 1 day,

...hrs. or ...min.?

8. OCCUPATION:

(a) Trade, profession, or particular kind of work

huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE,
(State or Country),

Baltimore, Md.

PARENTS.

10. NAME OF FATHER,

John Pickering

11. BIRTHPLACE OF FATHER
(State or Country),

Unknown

12. MAIDEN NAME OF MOTHER

Mary Muir

13. BIRTHPLACE OF MOTHER
(State or Country),

Md.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Chester Riland, Jr.

(Address).....

2532 Edmondson Ave.

15.

JUL 7 - 1915

Filed..... 191

H. KRAUTER

Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH,

July

5

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 5

1915

to July 5

1915

that I saw him alive on

July 5

1915

and that death occurred, on the date stated above, at 5:45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration).....

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

Bright's Disease

(Duration).....

yrs.

mos.

ds.

(Signed).....

Chester Riland

M. D.

7-5

1915

(Address).....

2532 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL.

National Cem

DATE OF BURIAL,

July 8, 1915

20. UNDERTAKER

William Cook

ADDRESS

502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Garrison & Dunal St.* 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Katherine A. Francis*(Residence in Baltimore: No. *Garrison & Dunal St.* 76 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>female</i>	4-COLOR OR RACE <i>white</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Widow</i> (Write the word.)
6-DATE OF BIRTH <i>Feb 8, 1838</i> (Month) (Day) (Year)		
7-AGE <i>76</i> yrs., mos. ds. If LESS than 1 day,hrs. or....min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		

9-BIRTHPLACE,
(State or Country), *Balto*

PARENTS.	10-NAME OF FATHER <i>John P. Francis</i>
	11-BIRTHPLACE OF FATHER (State or Country) <i>Ireland</i>
	12-MAIDEN NAME OF MOTHER <i>Mary A. Howell</i>
	13-BIRTHPLACE OF MOTHER (State or Country) <i>N.Y.</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *N. C. Groves*
(Address) *Garrison & Dunal St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 4, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 4, 1915*, to *July 2, 1915*, that I saw her alive on *July 2, 1915*, and that death occurred, on the date stated above, at *8:30 a.m.*
The CAUSE OF DEATH* was as follows:
*Old age*CONTRIBUTORY (Secondary) *Diagnosis of heart*
(Duration) yrs. mos. ds.(Signed) *Dr. H. P. McLean* M. D.
July 6, 1915 (Address) *2200 Euston Pl.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death?
Former or usual residence19-PLACE OF BURIAL OR REMOVAL, *Greenmount* DATE OF BURIAL, *July 7, 1915*
20-UNDERTAKER, *John C. Groves* ADDRESS *2200 Euston Pl.*15- *JUL 7 - 1915* *ROBERT KRAUTH*
Filed *1915* *Serial Permit Clerk*
Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 437 E 27th)2-FULL NAME Howard Joseph DeVos(Residence in Baltimore: No. 437 E 27th)ST. 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Single

6-DATE OF BIRTH

Aug251914

7-AGE

1010

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)None

9-BIRTHPLACE (State or Country)

Balto Md

10-NAME OF FATHER

John R DeVos

11-BIRTHPLACE OF FATHER (State or Country)

Md

12-MAIDEN NAME OF MOTHER

Martha O'Brien

13-BIRTHPLACE OF MOTHER (State or Country)

Md14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John R DeVos(Address) 437 E 27th St

15-

Filed

JUL 7 - 1915

ROBERT

KRAUTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July6191517- I HEREBY CERTIFY, That I attended deceased from June 24 1915, to July 6 1915, and that death occurred, on the date stated above, at 345 P. M.
The CAUSE OF DEATH* was as follows:
Gastro-Enteritis

CONTRIBUTORY (Secondary)

(Duration)

1mo.6

(Signed)

Geo. M. Murray

(Duration)

5mo.5

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

7mo.12da.

In the

State7mo.6

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

20-UNDERTAKER

DATE OF BURIAL

ADDRESS

New CathedralWilliam Cook1915602 E North

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH *W.D. Marine Hospital*
CITY OF BALTIMORE: (No. *112*) WARD (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *John Hickman*
Residence in Baltimore: No. *W.D. Marine Hospital* St. *1* yrs. *0* mos. *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS

1-SEX *Male*
2-COLOR OR RACE *Colored*
3-SINGLE *Widowed*
4-DATE OF BIRTH *Not Known*
5-AGE *49* If LESS than 1 day, hrs. min.?
6-OCCUPATION (a) Trade, profession or particular kind of work *Seaman*
(b) General nature of industry, business, or establishment in which employed (or employer) *Merchant Vessel*
7-BIRTHPLACE (State or country) *Va*
8-NAME OF FATHER *Not Known*
9-BIRTHPLACE OF FATHER (State or country) *Not Known*
10-MAIDEN NAME OF MOTHER *Not Known*
11-BIRTHPLACE OF MOTHER (State or country) *Not Known*

12-STATEMENT OF INFORMANT
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
His statement on admission to Hosp.
(Informant)
(Address)

MEDICAL CERTIFICATE OF DEATH

13-DATE OF DEATH *July 6, 1915*
14-I HEREBY CERTIFY, That I attended deceased from *July 25, 1915* to *July 6, 1915*
that I saw him alive on *July 15, 1915*
and that death occurred, on the date stated above, at *12* m.
THE CAUSE OF DEATH* was as follows:
Val. Disease heart
Mitral Insufficiency
Chronic Diffuse nephritis
Mitral Insufficiency
Contributory (SECONDARY)
(Signed) *M. D. [Signature]*
July 6, 1915 (Address) *W.D. Marine Hospital*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death *5* yrs. *11* mos. *11* ds. State *1* yrs. *0* mos. *0* ds.
Where was disease contracted, if not at place of death? *Unknown*
Former or usual residence *Unknown*

16-PLACE OF BURIAL OR REMOVAL *Laurel Cem* DATE OF BURIAL *July 8th 1915*
17-UNDERTAKER *Harry A. Vodary* ADDRESS *1725 Orleans St.*

18-*JUL 7 - 1915* *W. KRUTER,*
REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *Kate Ave. W. Malash Ave.* ST. *15* WARD)

FULL NAME *Alice M. Schaeffer*

(Residence in Baltimore: No. *Kate Ave. W. Malash Ave.* St. *15* yrs. *59* mos. *23* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

white

5-MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

Jan. 14, 1856
(Month) (Day) (Year)

7-AGE

59 yrs. *5* mos. *23* ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

work at home

9-BIRTHPLACE (State or country)

Balto Md

10-NAME OF FATHER

Jeremiah H. K. Kimberley

11-BIRTHPLACE OF FATHER (State or country)

unknown

12-MAIDEN NAME OF MOTHER

Olivia Staushury

13-BIRTHPLACE OF MOTHER (State or country)

Id.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herman Schaeffer

(Address)

Kate Malash Ave

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

July 7, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

July 1, 1915 to *July 7, 1915*

that I saw her alive on *July 6, 1915*

and that death occurred, on the date stated above, at *12 P. m.*

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) — yrs. — mos. *7* ds.

Contributory (SECONDARY)

(Duration) — yrs. — mos. — ds.

(Signed) *Edward H. London* M. D.
July 7, 1915 (Address) *750 W. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Green Mt. Cem.

DATE OF BURIAL

July 9, 1915

20-UNDERTAKER

Edw. Mitchell

JUL 7 - 1915

ROBERT KRAUTER

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *118 Hammerback St. 22* WARD)

REGISTERED NO. C

2-FULL NAME

Wm Oscar Miller

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *118 Hammerback St.* St.; *10* yrs., *2* mos., *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

*color*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *married*

6-DATE OF BIRTH.

April 6, 1889
(Month) (Day) (Year)

7-AGE.

26 yrs. 3 mos. 2 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Army labor
*Living State*9-BIRTHPLACE.
(State or Country).*Maryland*

PARENTS.

10-NAME OF FATHER.

*Eli Miller*11-BIRTHPLACE OF FATHER
(State or Country).*Annerunde Co*

12-MAIDEN NAME OF MOTHER

*Elizabeth Martiny*13-BIRTHPLACE OF MOTHER
(State or Country).*Annerunde Co*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Eli Miller*(Address) *836 Eastman*

15-

JUL 7 - 1915 *ROBERT KRAUTER,*
101 *Sanial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1, 1915, to *July 5, 1915*,that I saw him alive on *July 5, 1915*,and that death occurred, on the date stated above, at *3 a* m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
*chronic**about 7*
(Duration) *7* yrs. *2* mos. *2* ds.CONTRIBUTORY
(Secondary)(Duration) *7* yrs. *2* mos. *2* ds.(Signed) *B. A. Keeney* M. D.*July 7, 1915* (Address) *522 A. M. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *7* yrs. *2* mos. *2* ds. In the State *7* yrs. *2* mos. *2* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Turnace Branch *July 9, 1915*

20-UNDERTAKER

ADDRESS

W. L. Brown & Son *W. L. Brown & Son*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17-I HEREBY CERTIFY, That attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDE, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5161 - 2 700

Filed

JUL 7 - 1915

HARRY O. ANDREWS,

Morial Point, Clark

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 2503 E. Hoffman St 8 ST. 8 WARD) REGISTERED NO. C 67
FULL NAME Samuel A. Bersterman
(Residence in Baltimore: No. 2503 E. Hoffman St St.; 37 yrs., 7 mos., 16 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX Male 4-COLOR OR RACE White SINGLE, MARRIED, Married
(Write the word.)

6-DATE OF BIRTH Nov 19, 1877
(Month) (Day) (Year)

7-AGE 37 yrs., 7 mos., 16 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) Builder

9-BIRTHPLACE, (State or Country), Baltimore Maryland

10-NAME OF FATHER Frank Bersterman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Rimmel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Barbara Bersterman

(Address) 2503 E Hoffman

15- JUL 7 - 1915 HARRY O. ANDREWS,
Filed 1915 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July 6, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 6, 1914, to July 6, 1915, that I saw him alive on July 6, 1915, and that death occurred, on the date stated above, at 200 a.m. The CAUSE OF DEATH* was as follows:

General Paralysis
(Duration) 16 yrs., 16 mos., 16 ds.

CONTRIBUTORY (Secondary) Coma
(Duration) 1 yrs., 1 mos., 1 ds.
(State) Del. G. Queen M. D.
(Address) Front St. 1st St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death 37 yrs., 7 mos., 16 ds. In the State 37 yrs., 7 mos., 16 ds.

Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, July 7, 1915

20-UNDERTAKER William Cook ADDRESS 552 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C86505

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *1435 Boyle*)

2 FULL NAME

William M Leibold Jr.

(Residence in Baltimore: No. *1435 Boyle*)

St. *24* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *1hr* mos. *1hr* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX,

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) *Single*

6 DATE OF BIRTH

July 7, 1915
(Month) (Day) (Year)

7 AGE,

1 yrs. *1* mon. *1* ds.

If LESS than 1 day,

1 hrs. or *1* min.?

8 OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9 BIRTHPLACE,

(State or Country)

Baltimore

10 NAME OF FATHER

Wm M. Leibold

11 BIRTHPLACE OF FATHER

(State or Country)

Ind

12 MAIDEN NAME OF MOTHER

Minnie Graf

13 BIRTHPLACE OF MOTHER

(State or Country)

Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William M. Leibold Jr.*

(Address) *1435 Boyle*

15

JUL 7 - 1915

HARRY O ANDREWS,

Filed *1915*

EDWIN P. SMITH, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH

July 7, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prolonged Leukemia

(Duration) *1* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs. *1* mos. *1* ds.

(Signed) *Edwin P. Smith* M. D. (Coroner.)

July 7, 1915 (Address) *517 North St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park

7/7, 1915

20 UNDERTAKER

ADDRESS

J. F. McEntally 39 E. Fort St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Fg

HARRY O. ANDERSON,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) Alma S. Rollins, M.D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1014 Sterling St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 PLACE OF DEATH
CITY OF BALTIMORE (No. *436 W. Hamburg* — ST. *21* WARD) REGISTERED No. C
2 FULL NAME *George H. Dodson*
(Residence in Baltimore: No. *436 W. Hamburg* — St.: yrs., mos. *13* ds.)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX, *Male* 4 COLOR OR RACE, *Colored* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word)
6 DATE OF BIRTH, *June 23, 1915*
(Month) (Day) (Year)

7 AGE, *13* yrs., mos., ds. If LESS than 1 day, hrs. or min.

8 OCCUPATION:
(a) Trade, profession, or particular kind of work, *born*
(b) General nature of industry, business, or establishment in which employed (or employer).

9 BIRTHPLACE, (State or Country) *Baltimore*

10 NAME OF FATHER *Ernest Dodson*

11 BIRTHPLACE OF FATHER (State or Country) *Baltimore*

12 MAIDEN NAME OF MOTHER *Lena Chon*

13 BIRTHPLACE OF MOTHER (State or Country) *Calcutta India*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ernest Dodson*

(Address) *436 W. Hamburg*

15 JUL 7 - 1915 HARRY O. ANDREWS, Registrar

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH *July 6, 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Ed. Chase* (Duration) yrs. mos. ds.

(Coroner.) M. D.

July 7, 1915 (Address) *City of Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt. Auburn *July 7, 1915*

20 UNDERTAKER ADDRESS

L. L. Brown & Son *108 N. Maryland St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86508		HEALTH DEPARTMENT—CITY OF BALTIMORE		C86508	
		CERTIFICATE OF DEATH		x 115	
1 PLACE OF DEATH		REGISTERED NO. C.			
CITY OF BALTIMORE: (No. <u>Hebrew Hospital</u> ST. <u>7</u> WARD)		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)			
2-FULL NAME <u>James E Harrison</u>					
(Residence in Baltimore: No. <u>Kinston St. 6</u> St. <u>7</u> yrs. <u>7</u> mos. <u>7</u> ds.)					
PERSONAL AND STATISTICAL PARTICULARS					
3-SEX <u>male</u>	4-COLOR OR RACE <u>white</u>	5-SINGLE <u>married</u> MARRIED WIDOWED OR DIVORCED (Write the word)	16-DATE OF DEATH <u>July 6th 1915</u> (Month) (Day) (Year)		
6-DATE OF BIRTH <u>July 1st 1850</u> (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I attended deceased from <u>June 29, 1915</u> , to, <u>July 6th 1915</u> , that I saw him alive on <u>July 6th</u> 19 <u>15</u> , and that death occurred on the date stated above, at <u>8:25 a.m.</u>		
7-AGE <u>65</u> yrs. <u>7</u> mos. <u>7</u> ds. or min.?			The CAUSE OF DEATH* was as follows: <u>acute cholelithiasis</u>		
8-OCCUPATION (a) Trade, profession or particular kind of work <u>Solicitor</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Farm supplies</u>					
9-BIRTHPLACE (State or country) <u>James Co. N.C.</u>					
PARENTS	10-NAME OF FATHER <u>Harrison</u>		Contributory (SECONDARY) <u>uremic coma</u> (Duration) yrs. <u>Two</u> mos. <u>two</u> ds.		
	11-BIRTHPLACE OF FATHER (State or country) <u>N.C.</u>		(Signed) <u>M. B. Leven</u> M. D. <u>July 6th 1915</u> [Address] <u>Hebrew Hosp</u>		
	12-MAIDEN NAME OF MOTHER <u>Unknown</u>		* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
	13-BIRTHPLACE OF MOTHER (State or country) <u>N.C.</u>		18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS] At place of death... yrs. <u>7</u> mos. <u>7</u> ds. In the State yrs. <u>7</u> mos. <u>7</u> ds. Where was disease contracted, If not at place of death? <u>Kinston, N.C.</u> Former or usual residence <u>Kinston N.C.</u>		
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Stanley Whitaker</u> (Address) <u>Kinston N.C.</u>			19-PLACE OF BURIAL OR REMOVAL <u>Kinston N.C.</u> DATE OF BURIAL <u>July 7 1915</u>		
15- JUL 7 - 1915 HARRY O. ANDREWS, Social Permit Clerk REGISTRAR			20-UNDERTAKER <u>Joseph B Cook</u> ADDRESS <u>1003 N. E. 1st</u>		

C86509

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86509

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1754 Clarkson* ST.; *43* WARD)2-FULL NAME *Bernard L. MacKee*(Residence in Baltimore: No. *1754 Clarkson* St.; *15* yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Single*

6-DATE OF BIRTH,

*Feb**9**1895*

(Month)

(Day)

(Year)

7-AGE,

*20**4**27*

yrs.

mos.

ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Clerk
Hardware Store

9-BIRTHPLACE,

(State or Country), *Md.*

10-NAME OF FATHER,

Richard A. MacKee

11-BIRTHPLACE OF FATHER

(State or Country), *Md.*

12-MAIDEN NAME OF MOTHER

Mary L. Lloyd

13-BIRTHPLACE OF MOTHER

(State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. M. Clark*(Address) *1754 Clarkson*

15-

Filed

JUL 7 - 1915

191

HARRY O. ANDREWS,

Sanial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**6**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 1 1914, to *July 6* 1915,that I saw him alive on *July 6* 1915,and that death occurred, on the date stated above, at *6 P* m.

The CAUSE OF DEATH* was as follows:

Pseudo-Tuberculosis
(Adipose tissue)

(Duration)

yrs. *18* mos. ds.

CONTRIBUTORY

(Secondary)

(Duration)

yrs. mos. *7* ds.

(Signed)

R. A. Campbell M. D.*July 7* 1915 (Address) *1644 S. Avenue*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Landon Park Cemetery

DATE OF BURIAL,

July 9 1915

20-UNDERTAKER

R. A. Campbell

ADDRESS

1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1902 Hanover* ST. *73* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

2-FULL NAME *Sarah C Beebe*(Residence in Baltimore: No. *1902 Hanover* St. *40* yrs. *mos.* *ds.*)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)6-DATE OF BIRTH, *Aug 9*, 1872

(Month) (Day) (Year)

7-AGE, *42* yrs. *10* mos. *27* ds.

IF LESS than 1 day.

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Md.*

PARENTS.

10-NAME OF FATHER, *Thomas S. Rites*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER, *Catherine Harman*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. Beebe*(Address) *1902 Hanover St.*

15-

Filed *JUL 7 - 1915*

HARRY O. ANDREWS,

191. Serial Permit Olor's

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 6*, 1915

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 10* 1915, to *July 6* 1915, that I saw him alive on *July 6* 1915, and that death occurred, on the date stated above, at *5 P* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) *indeterminate* yrs. *mos.* *ds.*CONTRIBUTORY (Secondary) *Respiratory*(Duration) *indeterminate* yrs. *mos.* *ds.*(Signed) *R. Campbell* M. D.
July 6, 1915 (Address) *1644 Hanover St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cedar Hill Cemetery*DATE OF BURIAL, *July 8*, 191520-UNDERTAKER, *D. M. L. Flynn*ADDRESS, *1422 Light St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C. 40

CITY OF BALTIMORE: (No. 1

Hebrew Hospital

ST. 1

WARD)

2-FULL NAME

Eugenia M. E. Shaw

(If death occurred in a hospital or institution, give its NAME instead of street and number and Room No. 18.)

(Residence in Baltimore: No.

929 S. Kenwood Ave.

St. 1 yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widow

6-DATE OF BIRTH

Unknown 1865

(Month)

(Day)

(Year)

7-AGE

50

Yrs.

Mos.

Ds.

Or

Min.

If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

at Home

9-BIRTHPLACE

(State or country)

U.S.A. Md

10-NAME OF FATHER

Edgar Fairfield

11-BIRTHPLACE OF FATHER

(State or country)

Balto. Md.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or country)

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. Burns

(Address)

927 S. Kenwood Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 4, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 30, 1915, to July 4, 1915,

that I saw her alive on July 4, 1915,

and that death occurred, on the date stated above, at 7:00 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
Chronic Endocarditis
(Clinical Diagnosis) Con.

(Duration)

Yrs.

Mos.

Ds.

Contributory (SECONDARY)

Myocardial Degeneration

(Duration)

Yrs.

Mos.

Ds.

(Signed)

M. B. Lewis

M. D.

July 4, 1915

[Address]

Hebrew Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death Yrs. 5 Mos. 5 Ds. In the State Life

Where was disease contracted, 929 S. Kenwood Ave

If not at place of death?

Former or usual residence 929 S. Kenwood Ave

19-PLACE OF BURIAL OR REMOVAL

Balto. Conn.

DATE OF BURIAL

July 8, 1915

20-UNDERTAKER

Lilly Ziller

ADDRESS

403 S. Wolfe St

JUL 7 - 1915

HARRY O. ANDREWS,

FILE 191

Bartholomew Clerk

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2572 Rayner Ave ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. 2572 Rayner Ave St.; 16 yrs., 11 mos., 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH,

July, 16, 1914.
(Month) (Day) (Year)

7-AGE,

11 yrs., 21 mos., 21 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country).

Balto Md.

10-NAME OF FATHER,

James Harrison Johnson

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Leona Elizabeth Holland

13-BIRTHPLACE OF MOTHER

(State or Country),

City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Mother of Eliza Holland(Address).....2572 Rayner Ave

15-

JUL 8 - 1915BERT KRAUTHREGISTRAR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, 7, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 28 1915, to July 6 1915,that I saw him alive on July 6 1915,and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Anterior Poliomyelitis(Duration).....13 ds.CONTRIBUTORY
(Secondary)Pneumonia(Duration).....10 ds.(Signed).....Chas S. Parker M. D.July 7, 1915. (Address).....3116 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....11 yrs., 11 mos., 21 ds. In the State.....11 yrs., 11 mos., 21 ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Cathedral Cem. July 8, 1915.

20-UNDERTAKER

ADDRESS

Mr Edward W. Pyle 6 Winters Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *608. S. Bethel* ST.: *2* WARD)

2-FULL NAME

Ewa Galick(Residence in Baltimore: No. *608. S. Bethel* St.: *1* yrs., *9* mos., *4* da.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

*Oct.**11.**1913*

(Month)

(Day)

(Year)

7-AGE,

1 yrs., *9* mos., *4* da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

John Galick

11-BIRTHPLACE OF FATHER (State or Country),

Galicia, Austria

12-MAIDEN NAME OF MOTHER

Agnes Janeczko

13-BIRTHPLACE OF MOTHER (State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Galick

(Address)

608 S. Bethel

15-

*JUL 8 - 1915**ROBERT . KRAUTER*FIRM *APPL. 21. Permit 912*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**2**1915*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *July 3* 191*5*, to *July 7* 191*5*, that I saw h*er* alive on *July 7* 191*5*, and that death occurred, on the date stated above, at *12a* m.

The CAUSE OF DEATH* was as follows:

Enteric Colic

(Duration)

yrs.

mos.

da.

CONTRIBUTORY (Secondary)

Cardiac Pre-arrhythmia

(Duration)

yrs.

mos.

da.

(Signed)

Wm. J. Kane

M. D.

July 7, 1915

(Address)

2008 W. 10th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

da.

In the

State

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Holy Rosary**July 8, 1915*

20-UNDERTAKER

ADDRESS

William Fialkowski, 1611 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE; (No. *Maryland General Hosp.* ST.; *4* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME *Guiseppi Salvatore Maranto*Residence in Baltimore: No. *408 E. Pratt St.* St.: _____ yrs. _____ mos. *3* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single* (Write the word.)6-DATE OF BIRTH. *July 5, 1915* (Month) (Day) (Year)7-AGE. _____ yrs. _____ mos. *3* ds. If LESS than 1 day, _____ hrs. or _____ min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *None* (b) General nature of industry, business, or establishment in which employed (or employer) _____9-BIRTHPLACE, (State or Country). *Maryland*10-NAME OF FATHER. *Rosario Maranto*11-BIRTHPLACE OF FATHER (State or Country). *Italy*12-MAIDEN NAME OF MOTHER *Seraphina Matassa*13-BIRTHPLACE OF MOTHER (State or Country). *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rosario Maranto*(Address) *408 E. Pratt St.*15- *JUL 8 - 1915* *ROBERT E. BAUTER**1st DEPT. HEALTH CLERK*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *July 8, 1915* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 6, 1915*, to *July 8, 1915*, that I saw him alive on *July 8, 1915*, and that death occurred, on the date stated above, at *6 a.m.*The CAUSE OF DEATH* was as follows: *Acute Intestinal Obstruction*(Duration) _____ yrs. _____ mos. *3* ds.

CONTRIBUTORY (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *J. E. Dull* M. D.*July 8, 1915* (Address) *Md. General Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death _____ yrs. _____ mos. *3* ds. In the State _____ yrs. _____ mos. *3* ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence *408 E. Pratt St.*19-PLACE OF BURIAL OR REMOVAL *Md. General Hospital* DATE OF BURIAL *July 8, 1915*20-UNDERTAKER *John J. ...* ADDRESS *374 W. ...*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86515

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86515

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Black.

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Single

6-DATE OF BIRTH.

unknown, 1

(Month)

(Day)

(Year)

7-AGE.

26

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE,

(State or Country).

Charles Co. Md.

10-NAME OF FATHER.

John Day

11-BIRTHPLACE OF FATHER

(State or Country).

Charles Co. Md.

12-MAIDEN NAME OF MOTHER

Joanna Day.

13-BIRTHPLACE OF MOTHER

(State or Country).

Charles Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ellen J. Davis

(Address)

540 W. Biddle St.

15-

[Signature]

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 7th, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 18 1915, to July 7th 1915, that I saw her alive on July 7th 1915, and that death occurred, on the date stated above, at 8:45 am.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) David Street M. D.

July 7, 1915. (Address) 712 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 337 Courtland St.

Former or usual residence 337 Courtland St.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Peter's Cemetery

July 9th 1915

20-UNDERTAKER

ADDRESS

Eli G. Pye

102 E. Mulberry St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 8 - 1915

[Signature]

Registrar.

16- Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86516

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Mercy Hospital*)

ST. *11*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Catherine H Wanner

(Residence in Baltimore: No. *801 N Calvert*)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Child*

6-DATE OF BIRTH,

May 12, 1907
(Month) (Day) (Year)

7-AGE,

8 yrs. *1* mos. *24* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Child school girl

9-BIRTHPLACE, (State or Country),

Ma

PARENTS.

10-NAME OF FATHER,

Geo W Wanner

11-BIRTHPLACE OF FATHER (State or Country),

Ma

12-MAIDEN NAME OF MOTHER

Catherine Higinbotham

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo W Wanner*

(Address) *801 N Calvert St*

JUL 8 - 1915

Filed

1915

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 6, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*
(Inquest, au-

Inquiry find that said deceased came to death
topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns of 2nd degree
from fire in kitchen
(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) *Edward J Russell* M. D.

(Coroner.) *July 7, 1915* (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death....yrs....mos....ds. State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

801 N. Calvert St.

Former or usual residence *801 N. Calvert St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Balto Cem

July 9, 1915

20-UNDERTAKER,

ADDRESS

W J Pickens north Penn

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infirmary* ST.; *14* WARD)

2-FULL NAME

Clara Goode

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Vincent's Infirmary* St.; yrs. *2* mos. *14* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

March 27, 1915
(Month) (Day) (Year)

7-AGE,

9 yrs. *7* mos. *7* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUL 8 - 1915

Filed..... 191

ROBERT KRAUTER,

Official Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 4, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1st 1915, to July 4 1915,
that I saw her alive on *July 4 1915,*and that death occurred, on the date stated above, at *8:00 p.m.*

The CAUSE OF DEATH* was as follows:

Malnutrition + Malassimilation(Duration) yrs. *2* mos. *7* ds.CONTRIBUTORY
(Secondary)(Duration) yrs. *2* mos. *7* ds.(Signed) *Edmer. G. Hall* M. D.*July 5, 1915.* (Address) *1617 E. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. *14* ds. In the State yrs. *3* mos. *7* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery *July 8, 1915*

20-UNDERTAKER

ADDRESS

Marion S. Ahern Sons 606 Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs., *2* mos. *14* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Single*

6-DATE OF BIRTH,

March *20*, 19*15*
(Month) (Day) (Year)

7-AGE,

yrs. *9* mos. *14* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country).*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUL 8 - 1915

KRAUTER,
MARTIN

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July *5*, 19*15*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 1st* 1915, to *July 4th* 1915, that I saw her alive on *July 4th* 1915, and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH* was as follows:

Malnutrition & Malassimilation(Duration)....yrs. *2* mos.ds.CONTRIBUTORY
(Secondary)

(Duration)....yrs.mos.ds.

(Signed) *Charles G. Hall* M. D.*July 5, 1915* (Address) *1617 E. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. *14* ds. In the State yrs. *9* mos. *14* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral Cem**July 8, 1915*

20-UNDERTAKER

Martin Fahy Sons 616 Fayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86519

104

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Schuster of street and number and
all out No. 18.)
(Residence in Baltimore: No. 230 Albemarle St.; yrs. mos. ds.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 6 1915, to July 7 1915
that I saw him alive on July 7 1915
and that death occurred, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows:

Acute intestinal indigestion.....
..... (Duration)..... yrs..... mos. 10 d.

CONTRIBUTORY.....*None*.....
(Secondary)
..... (Duration).....*yr.*.....*mo.*.....*da.*

(Signed) G. A. Baller M. D.

July 7, 1915. (Address) J. H. Brown, Ltd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 21 ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death? No. Known

Former or usual residence 230 Albemarle St.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
15 23	8

20-UNDERTAKER	ADDRESS
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15- JUL 8 - 1915, 191. **COBERT . KRAUTH**
 Filed..... **Serial Permit**.....
 Registrar.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86520

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86520

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 19 W Hughes St
FULL NAME Mamie Cook
(Residence in Baltimore: No. 19 Hughes St
St. 22 WARD 22
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
St. 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX, Female
4 COLOR OR RACE, Colored
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
(Write the word)
6 DATE OF BIRTH, 1 1887.
(Month) (Day) (Year)
7 AGE, 28 yrs., mos. ds.
If LESS than 1 day, hrs. or min.?
8 OCCUPATION, (a) Trade, profession, or particular kind of work, Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
9 BIRTHPLACE, (State or Country), Md
10 NAME OF FATHER, Richard Johnson
11 BIRTHPLACE OF FATHER, (State or Country), Md
12 MAIDEN NAME OF MOTHER, Johanna Bailey
13 BIRTHPLACE OF MOTHER, (State or Country), Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johanna Bailey
(Address) 9 Hughes St

15 JUL 8 - 1915
Filed 1915
Registral

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH, July 6, 1915
(Month) (Day) (Year)
17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, and that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pistol shot wound in back pistol in hands some person unknown to jury
(Duration) yrs. mos. ds.
CONTRIBUTORY Internal Hemorrhage
(Secondary)
(Duration) yrs. mos. ds.
(Signed) E. J. ... M. D.
(Coroner.)
July 8, 1915. (Address) 517 Scott St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

20 UNDERTAKER, ADDRESS

John H. Pradine 1420 W. ...

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1144 Sargeant*)ST. *21* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1144 Sargeant*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married* (Write the word.)6-DATE OF BIRTH, *July 9th*, 18*48* (Month) (Day) (Year)7-AGE, *66* yrs., *11* mos., *27* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer), *wife*9-BIRTHPLACE, (State or Country), *Frederick Co Md*10-NAME OF FATHER, *Warren Grimes*11-BIRTHPLACE OF FATHER (State or Country), *Frederick Co*12-MAIDEN NAME OF MOTHER, *Margaret Browning*13-BIRTHPLACE OF MOTHER (State or Country), *Frederick Co*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Addie Price*(Address) *1144 Sargeant St.*15- JUL 8 - 1915 *W. H. KRAUTER* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 6th*, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 20* 1915, to *July 5* 1915, that I saw her alive on *July 5* 1915, and that death occurred, on the date stated above, at *2 P* m. The CAUSE OF DEATH* was as follows:*Paralysis of Heart*(Duration)..... yrs..... mos. *1*..... ds. CONTRIBUTORY *arterio sclerosis* (Secondary)(Duration)..... yrs. *2*..... mos..... ds.(Signed) *Shepherd M. D.* July 7, 1915. (Address) *1227 Calhoun St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Balto Gen* DATE OF BURIAL, *July 9th* 191520-UNDERTAKER, *John J. Cowan & Holmes* ADDRESS *Sou*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1002 Spaca* ST.: *21* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Wilmer L. Weisman*(Residence in Baltimore; No. *1002 Spaca* St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) *Infant*

6-DATE OF BIRTH,

June 19, 1915
(Month) (Day) (Year)

7-AGE,

No yrs. 10 mos. 19 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Infant*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *Louis Weisman*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER *May Thorpe*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louis Weisman*(Address) *1002 Spaca St.*

15-

JUL 8 - 1915.

Filed..... 191.....

HARRY KRAUTER, REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 8, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *June 19, 1915*, to *July 8, 1915*, that I saw him alive on *July 4, 1915*, and that death occurred on the date stated above, at *5 a. m.*

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Unassisted Delivery*

(Duration) yrs. mos. ds.

(Signed) *R. C. [illegible] M. D.**July 8, 1915.* (Address) *Not known*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Western Cemetery**July 8, 1915.*

UNDERTAKER

ADDRESS

*James Dugan & Son,**1000 S. Paca St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *236 S. Calhoun* ST. *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

2-FULL NAME *George A. Schneiderman*Residence in Baltimore: No. *236 S. Calhoun* St. — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE. *White*5-SINGLE, MARRIED, WIDOWED, DIVORCED.
(Write the word.) *Married*6-DATE OF BIRTH, *Jan 7, 1875*

(Month)

(Day)

(Year)

7-AGE, *40 6*

yrs. — mos. — ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Barber*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country), *U.S.*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER
(State or Country), *U.S.*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER
(State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. J. D. McGuire*(Address) *236 S. Calhoun St.*

15-

JUL 8 - 1915

Filed

LARRY O. JENKINS
Chief Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 7, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 1915*, to *July 7, 1915*,that I saw him alive on *July 6, 1915*,and that death occurred, on the date stated above, at *5 A* m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) *2* yrs. — mos. — ds.CONTRIBUTORY
(Secondary) *Coronary atherosclerosis*(Duration) *1* yrs. — mos. — ds.(Signed) *E. O. Heald* M. D.*July 7, 1915* (Address) *236 S. Calhoun St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSFERS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *New Cathedral Cemetery*DATE OF BURIAL, *July 8, 1915*

20-UNDERTAKER

ADDRESS

John J. Fields 1200 N. Lombard St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 East 31st.

ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME James Henry Spring

(Residence in Baltimore: No. 419 East 31st. Street

St.: 61 yrs., 3 mos. 4 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

April 3, 1854, 1

(Month)

(Day)

(Year)

7-AGE,

61 yrs., 3 mos., 4 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer).Clark
office9-BIRTHPLACE,
(State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

John Spring

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Elizabeth Goldsmith

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chester T. Melvin

(Address) Norfolk, Va.

JUL 8 - 1915

Filed 191

HARRY O. ANDREWS

Marital Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 7, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from March 30 1915, to July 7 1915, that I saw him alive on July 7 1915, and that death occurred, on the date stated above, at 12:50 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(Clinical Diagnosis)

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John Girdwood M. D.

July 8, 1915 (Address) 102 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. John's Family-Worship

DATE OF BURIAL,

7/9/15, 1915

20-UNDERTAKER

Henry W. Means & Son

ADDRESS

805 N. Calvert St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST.; *9* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *William Francis Higgins*Residence in Baltimore: No. *3529 Greenmount Ave.* St.; *58* yrs., *11* mos., *19* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, *male*4-COLOR OR RACE, *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *July 18*, 18*56*

(Month)

(Day)

(Year)

7-AGE, *58* yrs., *11* mos., *19* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Police Sergeant*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), *Baltimore, Md.*10-NAME OF FATHER, *Richard Higgins*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER, *Margaret Arnold*13-BIRTHPLACE OF MOTHER (State or Country), *England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *John T. Higgins*(Address), *1119 E. North Ave.*

15-

JUL 8 - 1915

HARRY O. ANDREWS,

Filed

191

Baltimore Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 7*, 191*5*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 29* 191*5*, to *July 7* 191*5*, that I saw him alive on *July 6* 191*5*, and that death occurred, on the date stated above, at *6²⁶* am.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Septicæmia(Duration) *unknown* yrs., *0* mos., *0* ds.CONTRIBUTORY (Secondary) *Mitral Insufficiency*(Duration) *6* yrs., *0* mos., *0* ds.(Signed) *J. W. Vinton* Chf. M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death - yrs. - mos. *8* ds. In the *58* yrs., *11* mos., *19* ds.Where was disease contracted, if not at place of death? *unknown*Former or usual residence *3529 Greenmount Ave.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral Cemetery**July 10*, 191*5*.

20-UNDERTAKER

ADDRESS

Henry W. Means & Son 80.52, Calverton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 C86526

PLACE OF DEATH
CITY OF BALTIMORE (No. *28 E Hill* ST.: *22* WARD)
FULL NAME *Nicolaï Balachki*
Residence in Baltimore: No. *28 E. Hill*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

6 yrs., *7* mos., *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX, *male* 4 COLOR OR RACE, *white* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
6 DATE OF BIRTH, *Jan 1, 1915*
(Month) (Day) (Year)

7 AGE, *6* yrs., *7* mos., *7* ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE, (State or Country)

10 NAME OF FATHER *Henrietta Balachki*

11 BIRTHPLACE OF FATHER (State or Country) *Russia*

12 MAIDEN NAME OF MOTHER *Jofia Kunas*

13 BIRTHPLACE OF MOTHER (State or Country) *Russia*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ph. Balachki*

(Address) *28 E Hill*

15 JUL 8 - 1915.

HARRY O. ANDERSON

Filed 1915 Serial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH *July 5, 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*
(Inquest, autopsy or inquiry.) And that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cholera Infantum
(Duration) *2* yrs., *7* mos., *7* ds.

CONTRIBUTORY (Secondary) *Emaciation*

(Signed) *Edna Greenough* M. D.

July 8, 1915 (Address) *517 South*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *6* yrs., *7* mos., *7* ds. In the State *6* yrs., *7* mos., *7* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Stanislawas *July 8, 1915*

20 UNDERTAKER ADDRESS

John Golicianow 500 B. P. Ave.

977
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 509 Columbia Ave ST.; 22 WARD)
2-FULL NAME Theresa G. Filling
(Residence in Baltimore: No. 509 Columbia Ave St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
(Write the word.)
6-DATE OF BIRTH, Feb. 13th, 1913
(Month) (Day) (Year)
7-AGE, 2 yrs., 4 mos., 24 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.
10-NAME OF FATHER, Edward Filling
11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.
12-MAIDEN NAME OF MOTHER, Marie Stark
13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Filling
(Address) 509 Columbia Ave

15- HARRY O. ANDREWS,

JUL 8 - 1915 Serial Permit 0107
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 25 1915, to July 7 1915, that I saw her alive on July 7 1915, and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis

(Duration) yrs. mos. ds. 12
CONTRIBUTORY (Secondary) Pulmonary Congestion

(Signed) J. M. Delaney M. D.
July 8, 1915 (Address) 621 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary

July 7, 1915

20-UNDERTAKER

ADDRESS

Jas. Dignant Son 1000 S. Joca

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

142 C86528

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1911 W. North Ave.)

St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 15.)

2-FULL NAME Isaac Abrams,

(Residence in Baltimore: No. 1911 W. North Ave.,

St. 42 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6-DATE OF BIRTH April 15., 1836 (Month) (Day) (Year)

7-AGE 79 yrs. 2 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work retired (b) General nature of industry, business, or establishment in which employed (or employer) Merchant

9-BIRTHPLACE (State or country) London, Eng.

10-NAME OF FATHER Abram Abrams,

11-BIRTHPLACE OF FATHER (State or country) Eng.

12-MAIDEN NAME OF MOTHER Fannie Gruneszweig,

13-BIRTHPLACE OF MOTHER (State or country) Eng.,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miriam Abrams

(Address) 1911 W. North Ave.

JUL 8 - 1915

Filed....., 191

Barial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 7, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1915, to, July 7, 1915, that I saw him alive on July 7, 1915, and that death occurred, on the date stated above, at 9 P. M. The CAUSE OF DEATH* was as follows:

Other Enteric fever of food. Resulting in Gangrene

Contributory (Duration) yrs. 2 mos. ds.

(SECONDARY) Age

(Signed) Abraham Samuels M. D.

July 7, 1915 (Address) 1928 Canton Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Balto, Hebrew,

DATE OF BURIAL July 9th, 1915

20-UNDERTAKER

ADDRESS

David Soudan 118 South Bay

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C.

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed JUL 8 - 1915

191

HARRY O. ALLEN

MARIAL FORM

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I attended deceased from

April 30 1915, to July 7, 1915,

that I saw him alive on July 7, 1915,

and that death occurred, on the date stated above, at 0:45 PM.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis
Fractured Neck of Femur
(Accidental fall from bed)
(Duration) 7 yrs. 7 mos. 7 ds.

CONTRIBUTORY

(Secondary)

(Duration) 7 yrs. 7 mos. 7 ds.

(Signed) Elmer H. Hecox M. D.

7-7-1915 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 7 mos. 7 ds. State 7 yrs. 7 mos. 7 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 508 W. Fayette St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Carmel Cemetery July 9, 1915.

20-UNDERTAKER

ADDRESS

Albert C. Fuller 221 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;..... WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.;..... yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

JUL 9 - 1915

ROBERT KRAUTER,

1915 JUL 9 - 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

7/4 1915, to 7/7 1915,

that I saw him alive on 7/7 1915,

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

7-7-1915, 1915. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (a) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State 27 yrs..... mos..... ds.

Where was disease contracted, if not at place of death? Unknown.

Former or usual residence 623 Montgomery St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

C86531 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1730 St Paul St*ST. *12* WARD)

REGISTERED NO. C

2-L NAME

Joseph S. Smith(Residence in Baltimore: No. *1730 St Paul St*St. *79* yrs., *4* mos., *2* ds.)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

March 6, 1836
(Month) (Day) (Year)

7-AGE,

79 yrs., *4* mos., *2* ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

Retired Banker
Banker

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

John D. Smith

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Mary Ann Stenard

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Perry Williams*(Address) *1730 St Paul St*

15-

*ROBERT KRAUTER*JUL 9 - 1915, *1730 St Paul St*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 8, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 25 1915, to *July 8 1915*,that I saw him alive on *July 7 1915*,and that death occurred, on the date stated above, at *4:30 a.m.*

The CAUSE OF DEATH* was as follows:

Decomposition of Scars

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Joseph J. Hermon* M. D.*July 8 1915* (Address) *1631 St Paul St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. in the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Green Mount Cem.**July 10, 1915*

20-UNDERTAKER

ADDRESS

2111 Mitchell St 60 1201 N. Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1539 Orleans St ST. 6 WARD)FULL NAME Oliver C. Dorsey(Residence in Baltimore: No. 1539 Orleans St, St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, Female 4-COLOR OR RACE, Col. 5-SINGLE, Single, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, January 7, 1915 (Day) (Year)7-AGE, 6 yrs., 6 mos., ds. IF LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), Baltimore, Md.10-NAME OF FATHER, Washington C. Dorsey11-BIRTHPLACE OF FATHER (State or Country), Anna Arundel Co. Md.12-MAIDEN NAME OF MOTHER Flaura Spencer13-BIRTHPLACE OF MOTHER (State or Country), Anna Arundel Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Washington C. Dorsey(Address) 1539 Orleans St.

15-

JUL 9 1915

FILED

ROBERT H. KRAUTH
BALTIMORE, MD.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY That I attended deceased from July 7, 1915, to July 7, 1915, that I saw her alive on July 7, 1915and that death occurred, on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Cholera InfantumCholera Infantum

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) E. C. Mayfield Bay M. D.July 7, 1915 (Address) 430 E. Lombard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the yrs. mos. ds. State

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Asbury Cemetery July 9, 1915

20-UNDERTAKER ADDRESS

Chas. R. Bailey 1421 Jefferson St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86533

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Anna E. Morris*Residence in Baltimore: No. *Long Point Md.* St. *1* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word.)

6-DATE OF BIRTH *Nov 30 1908*

(Month)

(Day)

(Year)

7-AGE *6 7 5*

If LESS than 1 day

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *School Girl*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER *Samuel Morris*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER *Anna Murphy*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edmund Morris*(Address) *Calvert St.*

15-

Filed

JUL 9 - 1915

ROBERT

KRAUTH

Special Permit Qls

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 8 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 29 1915* to *July 8 1915*that I saw her alive on *July 8 1915*and that death occurred, on the date stated above, at *1:00 p.m.*

The CAUSE OF DEATH was as follows:

*My Heart Stopped**about 1 mos. 15 ds.*

CONTRIBUTORY (Secondary)

about 1 mos. 3 ds.(Signed) *Edward J. Smith M.D.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *10* yrs. *10* mos. *10* ds. In the State *Md.*Where was disease contracted, if not at place of death? *Long Point Md.*Former or usual residence *Long Point Md.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Long Point Md.

20-UNDERTAKER

ADDRESS

Edmund Morris

7 a.m.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86531

CERTIFICATE OF DEATH.

151 C86531

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *9 S. Fremont* ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *9 S. Fremont* St.;

yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *child*

6-DATE OF BIRTH.

July 1, 1915
(Month) (Day) (Year)

7-AGE.

yrs., mos., da. *8*

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None.*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country),*Maryland*

10-NAME OF FATHER,

*John Bailey*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Elva Lawley*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thomas H. Gabow*(Address) *Mercy Hospital*

15-

JUL 9 - 1915

Filed

191

J. KAUTER, REGISTRAR

J. KAUTER, REGISTRAR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 8, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 1, 1915, to July 8, 1915*that I saw him alive on *July 7, 1915*and that death occurred, on the date stated above, at *2 P.* m.

The CAUSE OF DEATH* was as follows:

Inanition - for -
mature time
(Duration) *8* yrs., mos., da.

CONTRIBUTORY

(Secondary)

(Duration) *8* yrs., mos., da.(Signed) *Edward P. Smith, M.D.**July 8, 1915* (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *8* yrs., mos., da. In the State *8* yrs., mos., da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Western Cemetery, July 10, 1915

20-UNDERTAKER

ADDRESS *1000**Geo J. Smith*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86535

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86535

CERTIFICATE OF DEATH.

PLACE OF DEATH *Water foot of Bush St.*
CITY OF BALTIMORE (No. *Water foot of Bush St.* ST. *18* WARD) REGISTERED No. C
FULL NAME *John Christopher*
(Residence in Baltimore: No. *1055 W Lexington* 25 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word)
6-DATE OF BIRTH *1870*
(Month) (Day) (Year)
7-AGE, *45* yrs. mos. ds. IF LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer). *General*

9-BIRTHPLACE.
(State or Country)

Va

10-NAME OF FATHER

John Christopher

11-BIRTHPLACE OF FATHER
(State or Country)

Va

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Lucy Christopher*

(Address) *1055 W Lexington*

15 JUL 9 - 1915

Filed

ROBERT KRAUTER

Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *July 8, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry* and that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Drowning (Accident)
Found in water foot of Bush St.

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Edw. Scott* M. D.
(Coroner.)

July 9, 1915. (Address) *517 Scott St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount Auburn Ctry.

July 10, 1915

20-UNDERTAKER

ADDRESS

Alfred J. Ireland

114 N. S. Charles St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 C86533
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1034 Leaden Hall* ST. *23* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1034 Leaden Hall* St. : yrs. mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Unknown*

6-DATE OF BIRTH,

Unknown

(Month) (Day) (Year)

7-AGE, *about**32*

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Labored (unknown)

9-BIRTHPLACE, (State or Country),

Unknown

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *C. H. Foster M. D.*(Address) *No Informant*

15-

JUL 9 - 1915

Filed

DEPT. OF HEALTH
OFFICIAL PERMIT CLERK
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 8, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 25 1915 to *July 8 1915*that I saw him alive on *July 7 1915*and that death occurred, on the date stated above, at *6:30 A.M.*

The CAUSE OF DEATH* was as follows:

*Tuberculosis**Phthisis Pulmonalis*(Duration) yrs. mos. ds. *12 ds.*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. *12 ds.*(Signed) *C. H. Foster* M. D.*July 8, 1915* (Address) *712 S. Street*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

HOPKINS HOSPITAL

DATE OF BURIAL,

JUL 8 - 1915

20-UNDERTAKER

ADDRESS

Commissioner Health

FOR ANATOMICAL PURPOSES

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86537

CERTIFICATE OF DEATH

151

C86537

1-PLACE OF DEATH
CITY BALTIMORE: (No. *St Elizabeth Home* ST. *4* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Grace Pressman*
Residence in Baltimore: No. *St Paul St* St. *3* yrs. *2* mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *colored* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH *March 2, 1915* (Month) (Day) (Year)
7-AGE *3* yrs. *2* mos. *2* ds. or min. If LESS than 1 day, hrs., min.
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

PARENTS
10-NAME OF FATHER
11-BIRTHPLACE OF FATHER (State or country)
12-MAIDEN NAME OF MOTHER
13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 8, 1915* (Month) (Day) (Year)
17-I HEREBY CERTIFY, That I attended deceased from *Apr 7, 1915* to *July 8, 1915*, that I saw him alive on *July 7, 1915*, and that death occurred, on the date stated above, at *12* m.
The CAUSE OF DEATH* was as follows:

*Alimentary Decomposition
(Chronic severe malnutrition)*

(Duration) *3* yrs. *2* mos. *2* ds.

Contributory (SECONDARY)

(Signed) *Edgar B. Stuedenwald* M.D.
July 8, 1915 [Address] *1616 Linden Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *2* yrs. *2* mos. *2* ds. In the State *2* yrs. *2* mos. *2* ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

COLLEGE OF P. & S.

20-UNDERTAKER
Commissioner Health.

JUL 9 - 1915

FOR ANATOMICAL PURPOSES

JUL 9 - 1915

ROBERT J. KRAUTH
Official Permit Clerk
REGISTRAR

Ignac Wonsik
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 C86538
 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2400 East Ave.* ST.; WARD)

2-FULL NAME

(Residence in Baltimore: No. *2400 East Ave.* St.; *27* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.**3-SEX.***Male***4-COLOR OR RACE.***White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
Married
 (Write the word.)

6-DATE OF BIRTH.

Unknown; 1
 (Month) (Day) (Year)

7-AGE.*27*

yrs. mos. ds.

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Tailor
(Means)

9-BIRTHPLACE.
(State or Country).*Austria***PARENTS.****10-NAME OF FATHER.***Ignac Wasik***11-BIRTHPLACE OF FATHER.**
(State or Country).*Austria***12-MAIDEN NAME OF MOTHER.***Elizabeth Wonsik***13-BIRTHPLACE OF MOTHER.**
(State or Country).*Austria***14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.**

(Informant)...

May Wasik

(Address)...

*2631 Harbison St.***15 JUL 9 - 1915**

Filed

191

ROBERT KRAUTER**MORAL PERMIT CLERK**

Registrar.

16-DATE OF DEATH.

July 7, 1915
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1, 1915, to July 7, 1915,

that I saw him alive on *July 6, 1915,*

and that death occurred, on the date stated above, at *4:30 p.m.*

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis

(Duration) *6* yrs. *6* mos. *—* ds.

CONTRIBUTORY
(Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.

(Signed) *Emil Novak* M. D.

July 8, 1915 (Address) *8232 Patterson St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.**DATE OF BURIAL.***St. Stanislaus Cem.**July 10, 1915***20-UNDERTAKER****ADDRESS***Stephen J. Rakowski**1079 S. Hemlock*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 H. Mary ST. 11 WARD)

2-FULL NAME

(Residence in Baltimore: No. 440 H. Mary St.; yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Col.

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH

August 22 1914
Month (Day) (Year)

7-AGE,

1 yrs. 5 mos. da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Lapwork

9-BIRTHPLACE,
(State or Country),Baltimore
440 H. Mary St.

PARENTS.

10-NAME OF FATHER,

Thos. Lorton

11-BIRTHPLACE OF FATHER
(State or Country),

Balt City

12-MAIDEN NAME OF MOTHER

Hester Johnson

13-BIRTHPLACE OF MOTHER
(State or Country),

Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

440 H. Mary St.

15-

Filed

JUL 9 1915

DEPT. OF HEALTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

7/8/1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

7/7/1915 to 7/8/1915

that I saw him alive on 7/8/1915

and that death occurred, on the date stated above, 10:30 AM

The CAUSE OF DEATH* was as follows:

Gastric-Enteritis

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) J. L. Ellis M. D.

7/9/1915, 1011 (Address) 924 Wood St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Lansdowne

DATE OF BURIAL,

Aug 10, 1915

20-UNDERTAKER

John A. Bailey

ADDRESS

117 W. 11th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86540

CERTIFICATE OF DEATH

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *Methodist Home for the Aged* ST. *70* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

Laura Isabel Webb

Residence in Baltimore: No.

Methodist Home for the Aged ST. *79* yrs. *1* mos. *14* ds.)
1100 W. Locust St. Baltimore 16

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word)

6 DATE OF BIRTH

June 24, 1836
 (Month) (Day) (Year)

7 AGE

79 yrs. *1* mos. *14* ds. or *14* min.?
 If LESS than 1 day, — hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE (State or country)

Baltimore

10 NAME OF FATHER

Alanson Webb

11 BIRTHPLACE OF FATHER (State or country)

Connecticut

12 MAIDEN NAME OF MOTHER

Louisa Myers

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

E. R. Heuchaw

(Informant)

(Address)

Methodist Home for the Aged

15

JUL 9 - 1915

ROBERT KRAUTER,

DIPLOMA NOTARIAL CLERK

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 8, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

April 12, 1915, to *July 8*, 1915.

that I saw him alive on *July 7*, 1915.

and that death occurred, on the date stated above, at *5 a. m.*

The CAUSE OF DEATH* was as follows:

Epithelial Carcinoma
(Clinical Diagnosis)
about yrs. *6* mos. *—* ds.

Contributory (SECONDARY)

unknown
 (Duration) yrs. mos. ds.

(Signed),

John Hood, M. D.
July 8, 1915 (Address) *630 W. Silver St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *15* yrs. *4* mos. *16* ds. In the *79* yrs. *—* mos. *—* ds.

Where was disease contracted, *unknown*
 If not at place of death?

Former or usual residence *unknown*

19 PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

July 10, 1915

20 UNDERTAKER

Geo J Smith

ADDRESS

1000 St Fayette 11

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86541

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

67

C86541

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1439 Muecke St.*)

ST. *16*

WARD

2-FULL NAME *Dr. H. Chambers*

(Residence in Baltimore: No. *1429 Muecke St.*)

St. *57* yrs. *16* mos. *16* ds.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

unknown

(Month)

(Day)

(Year)

7-AGE

61 yrs. *16* mos. *16* ds. or min.?

If LESS than

1 day, *16* hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

waiter

Public

9-BIRTHPLACE

(State or country)

Baltimore md

10-NAME OF FATHER

Dr. Chambers

11-BIRTHPLACE OF FATHER (State or country)

Balt. City

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Lotter Chambers
1439 Muecke St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 8

(Month)

1915

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1915, to, *July 8*, *1915*,

that I saw him live on *July 7*, *1915*,

and that death occurred, on the date stated above, at *4* m.

The CAUSE OF DEATH* was as follows:

Purpura of Brain

(Duration)

2 yrs.

mos.

ds.

Contributory (SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

Harry Boyd

M. D.

July 8, *1915*

[Address]

602 Columbia

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Not Auburn Cemetery

July 11, *1915*

20-UNDERTAKER

ADDRESS

Geo H Hooper

609 Little Rock

JUL 9 - 1915

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86542

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Harvard A. Kelly* *Ward*)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Princeton N.J.*)

St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female.

4-COLOR OR RACE.

*White.*5-SINGLE, MARRIED, *Single*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

July 5, 1864.
(Month) (Day) (Year)

7-AGE.

51 yrs. *4* mos. *4* da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Librarian—College

9-BIRTHPLACE, (State or Country).

Lamington N.J.

10-NAME OF FATHER.

Abraham Gasman

11-BIRTHPLACE OF FATHER, (State or Country).

New York.

12-MAIDEN NAME OF MOTHER.

Letitia H. Nassau

13-BIRTHPLACE OF MOTHER, (State or Country).

N.J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Letitia H. Gasman*(Address) *Princeton N.J.*

15- JUL 10 1915.

Filed..... 191.....

HARRY V. ANDERSON
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 9, 1915.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Sept 14, 1914 to *July 9, 1915.*that I saw her alive on *July 8, 1915.*and that death occurred, on the date stated above, at *10 a.m.*

The CAUSE OF DEATH* was as follows:

*Pneumoniae Sarcosae**Verified by operation.*(Duration) *9* yrs. *9* mos. *—* da.

CONTRIBUTORY (Secondary)

(Duration) *9* yrs. *9* mos. *—* da.(Signed) *Robert H. Lewis* M. D.*July 9, 1915.* (Address) *1418 E. 1st Place*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs. *9* mos. *9* da. In the State *9* yrs. *9* mos. *9* da.Where was disease contracted, if not at place of death? *Princeton N.J.*Former or usual residence *Princeton N.J.*

19-PLACE OF BURIAL OR REMOVAL.

Princeton N.J. *July 10, 1915.*

20-UNDERTAKER

Chas. G. Black 1201 W. Mulberry St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2243 Madison Ave ST. 13 WARD)

2—FULL NAME

Frank, Caroline Frank(Residence in Baltimore: No. 2243 Madison Ave St.; 12 yrs., 0 mos., 0 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3—SEX.

Female

4—COLOR OR RACE.

White5—SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) Widowed

6—DATE OF BIRTH.

June ?, 1843
(Month) (Day) (Year)

7—AGE.

72 yrs., 0 mos., 0 ds. If LESS than 1 day, yrs. or mos. or ds.

8—OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife
at Home9—BIRTHPLACE,
(State or Country).Gersweld, Germany

10—NAME OF FATHER.

Isaac Rosenstock

11—BIRTHPLACE OF FATHER

Gersweld, Germany

12—MAIDEN NAME OF MOTHER

Mukunin

13—BIRTHPLACE OF MOTHER

Gersweld Germany

14—THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Albert L. Frank
(Address) 2243 Madison Ave

15—

JUL 10 1915

Filed

191

HARRY O. ANDREWS,

REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16—DATE OF DEATH.

July 8, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from July 8 1915, to July 8 1915, that I saw her alive on July 8 1915, and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH was as follows:

Cerebral haemorrhage(Duration) 1/2 yrs., 0 mos., 0 ds.CONTRIBUTORY (Secondary) Arteriosclerosis(Duration) Many yrs., 0 mos., 0 ds.(Signed) Chas. C. Frank M. D.July 8, 1915. (Address) 2243 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18—LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19—PLACE OF BURIAL OR REMOVAL.

Baltimore

DATE OF BURIAL,

July 11, 1915

20—UNDERTAKER

David Soudheim

ADDRESS

1800 W. 12th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86541

HEALTH DEPARTMENT—CITY OF BALTIMORE

172 C86541

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.

2-FULL NAME

(Residence in Baltimore: No.

Mercy Hospital

Mary Donohue

215 N. Anny St.

St. 18 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., 25 mos.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH

February

8/8

7-AGE,

67

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Ireland

10-NAME OF FATHER,

Patrick Donohue

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary Molone

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Patrick Donohue (Brother)

(Address) 316 S. Stricker St.

15-

JUL 10 1915

HARRY O. ANDERSON

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

(Month)

2

(Day)

1915

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, Autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, Autopsy or inquiry.

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Shock following operation for fracture of femur.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture femur (accident)

(Duration) yrs. mos. ds.

(Signed) J. H. Chambers M. D.

July 9, 1915 (Address) 18 W. Franklin St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. 1 mos. ds. In the 25 yrs. mos. ds.

Where was disease contracted, if not at place of death?

215 N. Anny St.

Former or usual residence 215 N. Anny St.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Peter's Church, July 10, 1915

20-UNDERTAKER, ADDRESS

John J. Cooney, 908 Hollins St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86545

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C.....

CITY OF BALTIMORE: (No.....

ST.:.....

WARD).....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Bernard Hartman

(Residence in Baltimore: No.....

123 S. Castle

St.; *48* yrs.....

mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Aug

14, 191*5*

7-AGE

75 yrs. *10* mos. *10* ds.

If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Germany

PARENTS

10-NAME OF FATHER

Charles Hartman

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Mary Licket

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. Benedict

(Address)

Little Sisters of the Poor

15-

JUL 10 1915

HARRY O. ANDREWS,

Marital Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 8

191*5*

17- I HEREBY CERTIFY, That I attended deceased from

by record, 191*5*

that I saw him alive on *July 4*, 191*5*

and that death occurred, on the date stated above, at *6 p.* m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Hufmann (Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Signed), *A. Warner* M. D.

July 8, 191*5* [Address] *1133 Valley H*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *4* yrs. *6* mos. ds. State *48* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Little Sisters of the Poor*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacred Heart Cem.

July 10, 191*5*

20-UNDERTAKER

For J. Burr 1914 E. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C.

PLACE OF DEATH

CITY OF BALTIMORE (No. 27 S. Bond

St. 3

WARD)

FULL NAME.. Louis Lisansky

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 27 S. Bond

St.; yrs., / mos. / 11 / 11

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 16, 1913
(Month) (Day) (Year)

7-AGE,

1 yrs. 11 mos. 24 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Max Lisansky

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Fannie Lisansky

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Max Lisansky

(Address) 27 S. Bond St. Baltimore

15-

JUL 10 1915

HARRY O. ANDREWS,

191. Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 9, 1913
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry.) And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) David W. Jones M. D.
(Coroner)

July 9 1913 (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Reburied in Baltimore July 10 1915

20-UNDERTAKER

ADDRESS 1107 E

J. J. Jones & Co. Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86547

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1126 Carroll ST. 21 WARD)

2-FULL NAME Dorothy Schweinsberg

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)

(Residence in Baltimore: No. 1126 Carroll St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH Unknown 1895
(Month) (Day) (Year)

7-AGE 20 yrs. — mos. — ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION
(a) Trade, profession or particular kind of work Factory girl
(b) General nature of industry, business, or establishment in which employed (or employer) sewing (shirt)

9-BIRTHPLACE (State or country) md

PARENTS
10-NAME OF FATHER Geo Schweinsberg (deceased)
11-BIRTHPLACE OF FATHER (State or country) md
12-MAIDEN NAME OF MOTHER Lena Neubert
13-BIRTHPLACE OF MOTHER (State or country) md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr John J Schweinsberg
(Address) 1120 W Cress St

15-JUL 10 1915 HARRY O ANDREWS, REGISTRAR
Filed 191 Social Death Office

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16, 1915, to, July 7, 1915, that I saw her alive on July 7, 1915, and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:

Acute dilatation of heart
(Duration) yrs. — mos. — ds. 1 hr.
Contributory (SECONDARY) Acute Pulmonary Phthisis
Myopathoidosis
(Signed) M. G. Lichtenberg M.D.
7-6-15 191 [Address] 95 Greene St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, OR RECENT RESIDENTS]

At place of death 20 yrs. — mos. — ds. In the 20 yrs. — mos. — ds. State

Where was disease contracted, at place of death?

Former or usual residence Usual residence

19-PLACE OF BURIAL OR REMOVAL London Park, Md DATE OF BURIAL July 13, 1915

20-UNDERTAKER Geo Leimbach & Son ADDRESS 67 M. Prater

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86548

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 S. Collington ave ST. 1 WARD)

FULL NAME

Hester A. Mac Lea
(Residence in Baltimore: No. 117 S. Collington ave St. 60 yrs. mos. ds.)

REGISTERED NO. C

If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX,

Female

COLOR OR RACE,

White

SINGLE,

MARRIED, Widowed,
OR DIVORCED,
(Write the word.)

Widow

DATE OF BIRTH,

Jan 16, 1829
(Month) (Day) (Year)

AGE,

86 5 22
yrs. mos. da.If LESS than 1 day,
...hrs. or...min.?

OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business, or establishment in which
employed (or employer).

at home

BIRTHPLACE,
(State or Country),

Md.

NAME OF FATHER,

Moses Liddard

BIRTHPLACE OF FATHER
(State or Country),

Pa

MAIDEN NAME OF MOTHER

Eliza A. Cook

BIRTHPLACE OF MOTHER
(State or Country),

N. J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Daniel Mac Lea

(Address)

Charles St. apt 4

15-

JUL 10 1915

HARRY O. ANDERSON

Editorial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

DATE OF DEATH,

July 8, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
July 7 1915, to July 8 1915,
that I saw her alive on July 7 1915,
and that death occurred, on the date stated above, at 9:50 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 da.

CONTRIBUTORY
(Secondary)

Euthanasia

(Duration) yrs. mos. da.

(Signed) G. G. P. M. D.

July 7 1915 (Address) 2000 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR DISPOVAL

London Park

DATE OF BURIAL,

July 11, 1915

20-UNDERTAKER

Zirkler & Zirkler

ADDRESS 1739

E. E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86549 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

C86549

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1619 E Baltimore

ST.:

3

WARD)

REGISTERED NO. C

2-FULL NAME

Ferdinanda Richter

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1619 E Baltimore

St.:

65

yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

July

21,

1885

(Month)

(Day)

(Year)

7-AGE,

89

yrs.

11

mos.

17

ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

at Home

9-BIRTHPLACE,

(State or Country),

Germany

PARENTS.

10-NAME OF FATHER,

Not Known

11-BIRTHPLACE OF FATHER

(State or Country),

Not Known

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER

(State or Country),

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Barbara Weber

(Address)

1619 E Baltimore St

15-

JUL 10 1915

HARRY O. ANDERSON

191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

8,

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 6 1915, to July 8 1915,

that I saw her alive on July 7 1915,

and that death occurred, on the date stated above, at 7³⁰ m.

The CAUSE OF DEATH* was as follows:

Senile Bronchomas

Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duration) yrs. mos. ds.

(Signed) Geo. Clinton Bladen D.

7/9/15, 191... (Address) 1437 N. 73rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

1st German

DATE OF BURIAL,

July 11, 1915

20-UNDERTAKER

Peter Nicolaus

ADDRESS

2145 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1522 N. Lannale* ST.; *16* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1522 N. Lannale*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *60* yrs., *1* mos. *9* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

Married

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

*May**31**1855*

(Month)

(Day)

(Year)

7-AGE,

*60**1**9*

yrs.

mos.

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Clk.**office work*9-BIRTHPLACE,
(State or Country),*Baltimore Md.*

PARENTS.

10-NAME OF FATHER,

*Charles Horn*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Caroline Storr*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Anna Horn

(Address)

1522 N. Lannale St

15-

FILE

JUL 10 1915

191

HARRY O. ANDREWS

Bartol...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**9**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 15**1915*to *July 9**1915*that I saw him alive on *July 8* *1915*and that death occurred, on the date stated above, at *5* *20* a m.

The CAUSE OF DEATH* was as follows:

*Carcinoma of bladder**(Cystoscopic & microscopic examinations)*(Duration) *2* yrs. *1* mos. *9* ds.CONTRIBUTORY
(Secondary)(Duration) *2* yrs. *1* mos. *9* ds.(Signed) *Harry O. Andrews* M. D.*July 9, 1915* (Address) *737 N. Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs. *1* mos. *9* ds. In the State *1* yrs. *1* mos. *9* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Linden St Cem

DATE OF BURIAL,

July 12, *1915*

20-UNDERTAKER

Joseph Bloch

ADDRESS

1003 N. Baltimore

N. B. Every item of information should be carefully supplied. Full name should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *University Hospital* ST. *4* WARD)

2-FULL NAME

Morris Owens

(Residence in Baltimore: No. *Annapolis Junction*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

(Month) (Day) (Year) *1873*

7-AGE,

42

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Blacksmith*
(b) General nature of industry, business, or establishment in which employed (or employer). *General*

9-BIRTHPLACE,

(State or Country), *Maryland*

PARENTS.

10-NAME OF FATHER,

Lee Owens

11-BIRTHPLACE OF FATHER

(State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER

Mrs. Parley

13-BIRTHPLACE OF MOTHER

(State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. C. Owens*

(Address) *Annapolis Junction*

15-

JUL 10 1915

Filed

191

ROBERT K. KRAUTER

Official Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year) *July 9th, 1915*

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

topsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Infected wound of right thigh the result of an accidental explosion of a gun.

(Duration) yrs. mos. ds. *4*

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Moses M. Savage* M. D. (Coroner.)

July 10, 1915 (Address) *179 Madison Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. *3 hours* In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

at Annapolis Junction

Former or usual residence *Annapolis Junction*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Savage Md

July 10, 1915

20-UNDERTAKER

ADDRESS

Joe B. Cook

1003 W Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *434 N. Eden*)

FULL NAME *Mary E. Myer*

(Residence in Baltimore: No. *434 N. Eden St*)

REGISTERED No. C

ST. *5* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *colored* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word)

6-DATE OF BIRTH *unknown*, 1 (Year)
(Month) (Day)

7-AGE *57* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country) *md*

10-NAME OF FATHER *Frank Jasco*

11-BIRTHPLACE OF FATHER
(State or country) *md*

12-MAIDEN NAME OF MOTHER *osborn*

13-BIRTHPLACE OF MOTHER
(State or country) *md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Philip Myer*

(Address) *434 N. Eden St*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 8*, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 6*, 191*5*, to *July 8*, 191*5*, that I saw her alive on *July 7*, 191*5*, and that death occurred, on the date stated above, at *6:01* m. The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Contributory *Infinite page*
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) *J. C. Robinson* M. D.
July 8, 191*5* (Address) *611 N. Caroline St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Laurel Cemetery *July 11*, 191*5*

20-UNDERTAKER ADDRESS

R. O. Cross, 405 McElderry St

15 JUL 10 1915

ROBERT KRAUTER,
Official Permit Clerk
REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF
FATHER

11-BIRTHPLACE
OF FATHER
(State or country)

12-MAIDEN NAME
OF MOTHER

13-BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

JUL 10 1915

DEATH

DEATH

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory

(SECONDARY)

(Signed)

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,

state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or

HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,

or Recent Residents)

At place

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2900 E. Pratt ST.; 1 WARD)2-FULL NAME May Hicks Bennett(Residence in Baltimore: No. 2900 E. PrattREGISTERED No. C. 42

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 45 yrs., 6 mos., 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

Jan 8, 1870
(Month) (Day) (Year)

7-AGE,

45 yrs., 6 mos., 1 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House Work
at home9-BIRTHPLACE,
(State or Country),Balto Md.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

George W. Bennett
2900 E. Pratt St.

15-

Filed

JUL 10 1915

191

101101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 14, 1915, to July 7, 1915,that I saw h. alive on July 7, 1915,and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Infection of veins following
operation for cancer of breast(Duration) 7 yrs., 3 mos., 1 ds.CONTRIBUTORY
(Secondary)(Duration) 3 yrs., 3 mos., 1 ds.

(Signed)

Harry Gray, M. D.
July 9, 1915, (Address) 1508 W. Ray St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs., 6 mos., 1 ds. In the State 1 yrs., 6 mos., 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Loudon Park

DATE OF BURIAL,

July 10, 1915

20-UNDERTAKER

Lilly & Zeiler

ADDRESS

403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *548 N. Gay*)ST.; *10* WARD)

REGISTERED NO. C

2-FULL NAME

Mary Elizabeth Decker

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *548 N. Gay*)St.; *64* yrs., *11* mos., *23* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

September 15, 1850
(Month) (Day) (Year)

7-AGE,

64 yrs., *11* mos., *23* ds.

If LESS than 1 day,

...hrs. or...mins.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Sales lady

(b) General nature of industry, business, or establishment in which employed (or employer).

*Keyst. Store*9-BIRTHPLACE,
(State or Country),*Balto. Md.*10-NAME OF
FATHER,*Henry Decker*11-BIRTHPLACE
OF FATHER
(State or Country).*Germany*12-MAIDEN NAME
OF MOTHER*Anna M. Klockar*13-BIRTHPLACE
OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Anna P. Young(Address) *548 N. Gay St.*

15-

9161-01-706

1913

DEATH
1913
FOLIO
1913

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 8, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
July 1, 1915, to *July 8, 1915*,
that I saw her alive on *on July 8, 1915*,
and that death occurred, on the date stated above, at *10²⁹ a.m.*
The CAUSE OF DEATH* was as follows:*Mitral Insufficiency**#* (Duration) *1* yrs., *11* mos., *23* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs., *11* mos., *23* ds.(Signed) *Mary F. Leggett* M. D.*July 8, 1915* (Address) *128 Valley St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Holy Redeemer**July 12, 1915*

20-UNDERTAKER

ADDRESS

Henry Brooks Son 1301 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Maryland General Hospital,

CITY OF BALTIMORE (No. Linden ave. & Madison st. ST. 5 WARD)

REGISTERED NO. C

2-FULL NAME

Annie Russell Boucha,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 904 E. Fayette st.

St.: yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female,

4-COLOR OR RACE,

White,

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married,

6-DATE OF BIRTH,

Unknown,

(Month)

(Day)

(Year)

7-AGE,

21

yrs.

?

mos.

?

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

None,

9-BIRTHPLACE,

(State or Country),

Maryland,

10-NAME OF FATHER,

James Russell,

11-BIRTHPLACE

OF FATHER

(State or Country),

Maryland,

12-MAIDEN NAME

OF MOTHER

Mary Murray,

13-BIRTHPLACE

OF MOTHER

(State or Country),

Ireland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ellen Russell,

(Address) Hotel Joyce,

15-

JUL 10 1915

ROBERT J. KRAUTER,

Filed.....

1915

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

9th

1915,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia,

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

M. D.

(Coroner.)

July 9th 1915 (Address) 3310 W. North av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. 2 mos. In the 71

Where was disease contracted, if not at place of death?.....

Former or usual residence 904 E. Fayette

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *15* ST. *15* WARD)FULL NAME *Elmer Lewis*(Residence in Baltimore: No. *2129 Walbrook Ave* St. *40* yrs., *2* mos., *28* ds.)REGISTERED NO. C. *132*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*Married*

6-DATE OF BIRTH,

Apr. 10, 1875
(Month) (Day) (Year)

7-AGE,

40 yrs., 2 mos., 28 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework
*General*9-BIRTHPLACE.
(State or Country),*Md.*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUL 10 1915

RECEIVED

J. KRUTER

FORM 10-1-14

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 8, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 28, 1915, to *July 8, 1915*that I saw her alive on *July 8, 1915*and that death occurred, on the date stated above, at *9:00* m.

The CAUSE OF DEATH* was as follows:

*Salpingitis**Atrophy*
(Duration) *2* yrs., *2* mos., *2* ds.CONTRIBUTORY
(Secondary)*Edwards & Smith*
(Duration) *1* yrs., *2* mos., *2* ds.(Signed) *Edward & Smith* M. D.*July 8, 1915* (Address) *Mercy St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *10* yrs., *2* mos., *2* ds. In the *State* *10* yrs., *2* mos., *2* ds.Where was disease contracted, if not at place of death? *2129 Walbrook Ave*Former or usual residence *2129 Walbrook Ave*

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn

DATE OF BURIAL,

7/10, 1915

20-UNDERTAKER

Marian Cook

ADDRESS

1028 North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1119 Scott*ST. *21* WARD)

2-FULL NAME

Raymond Parker

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1119 Scott St.*

St.; yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

8

yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Md.*

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *Wm. H. Brack*(Address)..... *1119 Scott St.*

15-

Filed.....

*JUL 10 1915**W. H. Krauter**APR 11 1915*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 8, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 6, 1915* to *July 8, 1915*, that I saw him alive on *July 8, 1915*, and that death occurred, on the date stated above, at *6 p.m.*

The CAUSE OF DEATH* was as follows:

Cholera infantum

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

Malnutrition

(Duration)..... yrs. mos. ds.

(Signed)..... *M. B. Sullivan*..... M. D.*July 10, 1915* (Address)..... *682 Calverton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mt. Oliver

DATE OF BURIAL,

July 10, 1915

20-UNDERTAKER

Jas. Wignall & Son

ADDRESS

1000 S. Yaca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86560 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 507 W. Lafayette avenue, ST. 17 WARD)

FULL NAME Catherine Brandmiller,

(Residence in Baltimore: No. 507 W. Lafayette avenue,

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 58.)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Female 4-COLOR OR RACE. White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single, 6-DATE OF BIRTH. September 21st., 1858. (Month) (Day) (Year)

7-AGE. 56 yrs., 9 mos., 18 da. If LESS than 1 day,hrs. ormin.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS. 10-NAME OF FATHER. Michael Brandmiller, 11-BIRTHPLACE OF FATHER (State or Country). Germany, 12-MAIDEN NAME OF MOTHER. Catherine Martin, 13-BIRTHPLACE OF MOTHER (State or Country). Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Joseph A. Brandmiller, (Address) 507 W. Lafayette avenue...

15- JUL 10 1915, ROBERT KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 9th., 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy, (Probably of nephritic origin) (Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. da. (Signed) J. M. D. (Coroner) July 10, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death. yrs. mos. da. In the State. yrs. mos. da. Where was disease contracted, if not at place of death?...

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER ADDRESS

M. F. & Sons, 507 W. Lafayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asy.* ST. *14* WARD)

2-FULL NAME

Lucius Collins(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. / mos. *24* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

May 13th, 1915
(Month) (Day) (Year)

7-AGE,

yrs. *1* mos. *24* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

None

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUL 10 1915 ROBERT KRAUTER, REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 7th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1st 1915, to July 7 1915,
that I saw him alive on *July 7 1915,*and that death occurred, on the date stated above, at *10:07 a.m.*

The CAUSE OF DEATH* was as follows:

M. abnutrition & Mal assimilation

(Duration) yrs. / mos. / ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. / mos. / ds.

(Signed) *J. E. Coulton* M. D.*July 8, 1915* (Address) *615 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. / mos. *24* ds. In the State yrs. / mos. *24* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral July 10, 1915

20-UNDERTAKER

ADDRESS

M. Fahey & Sons 606 Lafayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86562

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *902 Bevan*)

ST. *23* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Margaret A. Haupt*

(Residence in Baltimore: No. *902 Bevan* St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6-DATE OF BIRTH *May 18, 1915*
(Month) (Day) (Year)

7-AGE *1* yrs. *2* mos. *21* ds. or *1* day, *21* hrs. or *1* min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Ind*

10-NAME OF FATHER *John A. Haupt*

11-BIRTHPLACE OF FATHER (State or country) *Ind*

12-MAIDEN NAME OF MOTHER *Margt Mueller*

13-BIRTHPLACE OF MOTHER (State or country) *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Mary Haupt*

(Address) *902 Bevan St*

15-*JUL 10 1915*
Filed

W. KRAUTER

APITAL permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 9, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 9, 1915, to, *July 9, 1915*.

that I saw her alive on *July 9, 1915*.

and that death occurred, on the date stated above, at *10 P. M.*

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. ds. *2* ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds. *2* ds.

(Signed) *W. K. Smith* M. D.

July 10, 1915 (Address) *128 Schaefer St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Western Cemetery

20-UNDERTAKER

Mrs. J. C. Evans

DATE OF BURIAL

July 12, 1915

ADDRESS

1428 Schaefer St

086563

C86563

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mon., ds.)

MEDICAL CERTIFICATE OF DEATH.

Jungle

(Year)

.....hr. of.....min.

June.

Highland Town Md.

Petrak v. Mamm

Balburn

Mary. Rode

Baltimore

(Address

JUL 10 1915

Registrar

July - 8, 1915
(Month) (Day) (Year)

and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Thrasma
Sistr. Entelido

CONTRIBUTORY.....*Chas. L. Harrison*
(Secondary)

(Duration)..... yrs..... mos..... ds
(Signed) William F. Sawyer D
7-9, 1915 (Address) 208 S. Howard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
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Holy Cross Con. July 11, 1913.

[illegible]

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86561

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *724 S. Wolfe*ST. *2* WARD)

REGISTERED NO. C

2-FULL NAME

Henry F. Schoenicks

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *724 S. Wolfe*St.; *1* yrs. *5* mos. *26* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Single

6-DATE OF BIRTH,

Jan 14, 191*7*
(Month) (Day) (Year)

7-AGE,

1 yrs. *5* mos. *26* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....*none*
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....9-BIRTHPLACE,
(State or Country),*Ind*

PARENTS.

10-NAME OF
FATHER,*Henry Schoenicks*11-BIRTHPLACE
OF FATHER
(State or Country),*Ind*12-MAIDEN NAME
OF MOTHER*Marie Walter*13-BIRTHPLACE
OF MOTHER
(State or Country),*Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Schoenicks*(Address) *724 S. Wolfe St*

15-

JUL 10 1915
Filed..... 191.....

ROBERT KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 9th, 191*5*
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from
June 25 191*5*, to *July 9* 191*5*,
that I saw him alive on *July 9* 191*5*,
and that death occurred, on the date stated above, at *3 P* m.

The CAUSE OF DEATH* was as follows:

Nephritis(Duration)..... yrs. mos. *14* ds.CONTRIBUTORY
(Secondary)*Dropsy*(Duration)..... yrs. mos. *7* ds.(Signed) *John H. Rehberger* M. D.*July 9*, 191*5* (Address) *1709 Alameda*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Trinity

DATE OF BURIAL,

July 12, 191*5*

20-UNDERTAKER

H. Sander & Sons

ADDRESS

12106 1/2 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *118-n. Potomac St.*)

2-FULL NAME

Emil Krause
118-n. Potomac St.

(Residence in Baltimore: No. *118-n. Potomac St.*)

REGISTERED NO. C. *126 C86565*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

Oct 26, 1835
(Month) (Day) (Year)

7-AGE

79 yrs. *8* mos. *13* ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired
Booker

9-BIRTHPLACE
(State or country)

Germany

10-NAME OF FATHER

Not known

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Amanda Krause

(Address)

118 N. Potomac St.

15-

Filed

JUL 10 1915

EMIL KRAUSE

HOSPITAL PERMIT CLERK

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 7, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Jan 5, 1915 to *July 7, 1915*

that I saw him alive on *July 7, 1915*

and that death occurred, on the date stated above, at *2:00 p.m.*

The CAUSE OF DEATH* was as follows:

Chronic Prostatitis

Contributor *Exhaustion*
(SECONDARY) (Duration) *1 1/2* yrs. *2* mos. *2* ds.

(Signed) *John G. Quinn*
July 8, 1915 (Address) *Franklin Ave. + Pine*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Matthews Cem.

20-UNDERTAKER

H. Sander Sons

DATE OF BURIAL

July 10, 1915

ADDRESS

170 Fleet St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *The Johns Hopkins Hospital* 7 WARD
 CITY OF BALTIMORE: (No. *3311 E. Baltimore St.*)
 2-FULL NAME *Charles F. Filler Jr.*
 (Residence in Baltimore: No. *3311 E. Baltimore St.* St.; *2* yrs., *5* mos., *5* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
 6-DATE OF BIRTH. *July 4, 1913*
 7-AGE. *2* yrs., *5* mos., *5* ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *none*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). *Md*

10-NAME OF FATHER, *Charles F. Filler*
 11-BIRTHPLACE OF FATHER, (State or Country), *Md*
 12-MAIDEN NAME OF MOTHER, *Hellen P. Pierpoint*
 13-BIRTHPLACE OF MOTHER, (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant). *Charles F. Filler*
 (Address). *3311 E. Baltimore St.*

15-*JUL 10 1915*
 Filed. *101* *DEPT. OF HEALTH* *REGISTRAR*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 9, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 19, 1915*, to *July 9, 1915*, that I saw him alive on *July 9, 1915*, and that death occurred, on the date stated above, at *10:45 pm*.

The CAUSE OF DEATH* was as follows:

Polio myelitis
 (Duration) yrs. mos. *20* ds.

CONTRIBUTORY (Secondary) *none*

(Signed) *G. A. Baller* M. D.
7/9, 1915 (Address) *Johns Hopkins*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. *20* ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death? *has been*

Former or usual residence *3311 E. Baltimore St*

19-PLACE OF BURIAL OR REMOVAL, *St. Anne's* DATE OF BURIAL, *July 12, 1915*

20-UNDERTAKER *Sander & Sons* ADDRESS *1708 N. E. St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *818* *Coxon* St.; *10* WARD)

2-FULL NAME

(Residence in Baltimore: No. *818* *Coxon* Street St.; yrs., mos. ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Possibly *January* (?) *1856*
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,

19? yrs. mos. ds.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

waiter
Public

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

PARENTS.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Arthur L. Smith*(Address) *538 N. Bond St.*

15-

JUL 10 1915
Filed..... 191.....*JOSEPH KRAUTER*
Sup'l Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July *9*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

10 June 1915 to *9 July 1915*that I saw him alive on *9 July 1915*and that death occurred, on the date stated above, at *10:10 a.m.*

The CAUSE OF DEATH* was as follows:

*Acute Bright's Disease**Added 3 days**CONTRIBUTORY* *Cerebral Apoplexy**(Secondary)* *(Duration) yrs. mos. ds.**(Signed)* *A. Quayfield* *M. D.**10-7-1915* (Address) *1430 N. Carroll St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Funeral Home *July 11 1915*

20-UNDERTAKER,

ADDRESS

Samuel J. Newberry *578 N. Biddle*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86563

CERTIFICATE OF DEATH

18

C86563

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *396 Old York Road* ST. *9* WARD)

2-FULL NAME *Agusta Virginia Nash*

(If death occurred in a hospital or institution, give its NAME instead of street and number and Rm out No. 18.)

(Residence in Baltimore: No. *396 Old York Road* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

September 15th 1879
(Month) (Day) (Year)

7-AGE

35 yrs. *9* mos. *24* ds. or min.?

If LESS than
1 day, hrs.
min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Homemaker

9-BIRTHPLACE
(State or country)

Ind.

PARENTS

10-NAME OF FATHER

Lewis J. Strieter

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Katherine Ringdorf

13-BIRTHPLACE OF MOTHER
(State or country)

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eugene West

(Address)

296 Old York Road

15-

JUL 10 1915
Filed

ROBERT KRAUTER

MISS M. M. FORT

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 9th 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 30th 1915, to *July 9th 1915*,

that I saw her alive on *July 9th 1915*,

and that death occurred, on the date stated above, at *11 A.M.*

The CAUSE OF DEATH* was as follows:

Corynebacterium

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *Geo. W. Murgatroyd M.D.*

July 9th 1915 [Address] *2537 Greenmount Ave*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery July 12 1915

20-UNDERTAKER

ADDRESS

Henry Lutz 1007 N. Bond St

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *16* WARD)

2-FULL NAME

(Residence in Baltimore: No. *924 N Carrollton Ave* St. *30* yrs. *30* mos. *30* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word)

Married

6-DATE OF BIRTH,

Sept 17, 18*77*

(Month)

(Day)

(Year)

7-AGE,

37 yrs. *9* mos. *21* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

Chauffer
private family

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Wm Renna

11-BIRTHPLACE

OF FATHER

(State or Country),

Germany

12-MAIDEN NAME

OF MOTHER

Julia Schaub

13-BIRTHPLACE

OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

Julia Renna
924 N Carrollton Ave

15-JUL 10 1915

Filed....., 191.....

Burial Permit Given

Registrar.

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *July 4* 191*5* to *July 9* 191*5*, that I saw him alive on *July 9* 191*5*, and that death occurred, on the date stated above, at *8:50 a.m.*

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia

(Duration).....

yrs.....

mos.....

ds.....

CONTRIBUTORY.....

(Secondary)

Operative Laparotomy for Tuberculous Peritonitis

(Signed).....

R. J. Johnson

M. D.

July 9, 1915. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs.....

mos.....

ds.....

In the

State

yrs.....

mos.....

ds.....

Where was disease contracted,

if not at place of death?

924 N Carrollton Ave

Former or

usual residence

Baltimore Md

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Western Cemetery**July 12, 1915*

20-UNDERTAKER

George J. Smith

ADDRESS

1000 N. Gwynette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 N. Bethel ST.; 8- WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John Malen Tuder
(Residence in Baltimore: No. 1718 N. Bethel St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word.)
Single

6-DATE OF BIRTH

July 14, 1893
(Month) (Day) (Year)

7-AGE

22 4 24
yrs. mos. ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Carpenter
(Buildings)9-BIRTHPLACE,
(State or Country),Baltimore
Malen Tuder

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),Margaret Catherine
Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Malen Tuder
1718 N. Bethel St.

15-

JUL 10 1915
Filed..... 101.....DEPT. OF HEALTH
BALTIMORE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 8, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 4, 1915, to July 8, 1915, that I saw him alive on July 8, 1915, and that death occurred, on the date stated above, at 6:25 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin B. Tilden, D.

July 8, 1915. (Address) 1223 N. Beaman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

St. Matthews Church July 11, 1915

20-UNDERTAKER

ADDRESS

R. T. T. T. T. 1442 N. Brady

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

13. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH *Mersey Hospital* REGISTERED No. C *4*
CITY OF BALTIMORE (No. *8*) ST. *4* WARD *4*
FULL NAME *James J. Moore* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *741 Pennington Ave., Curtis Bay* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*
6-DATE OF BIRTH, *February 15th, 1860*
(Month) (Day) (Year)
7-AGE, *55* yrs. *4* mos. *20* ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Former work*
(b) General nature of industry, business, or establishment in which employed (or employer). *oil company*

9-BIRTHPLACE, (State or Country), *Richmond, Va*

PARENTS.
10-NAME OF FATHER, *Anderson Moore*
11-BIRTHPLACE OF FATHER (State or Country), *Virginia*
12-MAIDEN NAME OF MOTHER, *Gould Hutton*
13-BIRTHPLACE OF MOTHER (State or Country), *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Miss James Moore*
(Address) *741 Pennington Ave., Curtis Bay*

15- JUL 10 1915 ROBERT KRAUTER, Registrar.
Filed..... 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 8, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquest*, and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:
Compound fracture of Tibia and Fibula caused by his left leg being accidentally caught by the wheel of a moving wagon (Duration) *3* yrs. *3* mos. *3* ds.
CONTRIBUTORY *Chronic Interst. Nephritis* (Secondary) (Duration) *3* yrs. *3* mos. *3* ds.

(Signed) *Wm. McSavage* M. D. (Coroner.)
July 9, 1915 (Address) *1729 Madison Ave.*

*State the DISEASE CAUSING DEATH or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death *3* yrs. *3* mos. *3* ds. In the State *3* yrs. *3* mos. *3* ds.
Where was disease contracted, if not at place of death? *at Curtis Bay*
Former or usual residence *741 Pennington Ave.*

19-PLACE OF BURIAL OR REMOVAL, *Richmond, Va* DATE OF BURIAL, *July 11, 1915*
20-UNDERTAKER, *D. L. M. Flynn* ADDRESS *722 Light St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH *Providence Hospital* 14 REGISTERED NO. C
 CITY OF BALTIMORE: (No. *St.* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 FULL NAME *Mary E. Bodridge*
 (Residence in Baltimore: No. *419 Mosher* St.: *74* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widow*
 (Write the word.)
 6-DATE OF BIRTH, *Unknown*, 18*41*.
 (Month) (Day) (Year)
 7-AGE, *74* yrs., mos. ds. If LESS than 1 day.
 ...hrs. or...min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Cook*
 (b) General nature of industry, business, or establishment in which employed (or employer). *Private family*

9-BIRTHPLACE, (State or Country), *City*

10-NAME OF FATHER, *Unknown*
 11-BIRTHPLACE OF FATHER (State or Country), *Unknown*
 12-MAIDEN NAME OF MOTHER, *Unknown*
 13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *Mrs. Margaret Frasier*
 (Address) *419 Mosher St.*

15- *ROBERT J. KRAUTER*
 JUL 10 1915, *SERIAL PERMIT CLERK*
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 8*, 191*5*.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr. 17* 191*5*, to *July 8* 191*5*, that I saw h *er* alive on *July 7* 191*5*, and that death occurred, on the date stated above, at *1:30* p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.
 (Operation) (Duration) *7* yrs., mos. ds.

CONTRIBUTORY (Secondary) *Atrophic.*
 (Duration) *7* yrs., mos. ds.

(Signed) *W. E. East, Jr., M. D.*
July 8 191*5*. (Address) *515 Mosher St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *6 wks* In the *74* yrs. mos. ds.

Where was disease contracted, if not at place of death? *at home*

Former or usual residence *419 Mosher St.*

19-PLACE OF BURIAL OR REMOVAL, *Laurel Cemetery* DATE OF BURIAL, *July 11, 1915*

20-UNDERTAKER, *George H. Holland* ADDRESS *577 Robert St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1319 Light*

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1319 Light*ST. *24*

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Black

5-SINGLE,

MARRIED, *Single*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

July 7, 1915
(Month) (Day) (Year)

7-AGE.

If LESS than 1 day,
2 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer)*None*

9-BIRTHPLACE.

(State or Country), *MD*10-NAME OF
FATHER, *Walter Franklin*11-BIRTHPLACE
OF FATHER(State or Country), *MD*12-MAIDEN NAME
OF MOTHER *Maggie Green*13-BIRTHPLACE
OF MOTHER(State or Country), *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Maggie Green*(Address) *Brooklyn MD*

15-

Filed

JUL 10 1915

ROBERT J. KRAUTER,

SPECIAL PERMIT CLERK

Registrar.

16-PLACE OF BURIAL OR REMOVAL.

COLLEGE OF P. & S.

DATE OF BURIAL.

JUL 10 1915

20-UNDERTAKER

Commissioner Health.

ADDRESS

FOR ANATOMICAL PURPOSES

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital 15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Louis Sabatino*(Residence in Baltimore: No. *3439 Piedmont Ave (Walbrook 1)* St.;

yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

unknown, 1879
(Month) (Day) (Year)

7-AGE,

36 yrs. - mos. - da.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Merchant*(b) General nature of industry, business, or establishment in which employed (or employer) *Shoes & Hats*9-BIRTHPLACE,
(State or Country), *Italy*10-NAME OF FATHER, *Bernard Sabatino*11-BIRTHPLACE OF FATHER
(State or Country), *Italy*12-MAIDEN NAME OF MOTHER *Mary Conorato*13-BIRTHPLACE OF MOTHER
(State or Country), *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Sabatino*(Address) *3439 Piedmont Ave.*

15-

JUL 10 1915

Filed

H. KRAUTER,
Regist. Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, *8*, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 25* 1915, to *July 8* 1915, that I saw him alive on *July 8* 1915, and that death occurred, on the date stated above, at *5:30 P.M.*

The CAUSE OF DEATH* was as follows:

Toxaemia from sepsis
Peritonitis(Duration) yrs. mos. da. *3*CONTRIBUTORY (Secondary) *Appendicitis*(Duration) yrs. mos. da. *26*(Signed) *R. L. Johnson* M. D.*July 8*, 1915. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *13* da. In the State *?* yrs. *?* mos. *?* da.Where was disease contracted, if not at place of death? *3439 Piedmont Ave*Former or usual residence *Baltimore*

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cem.

DATE OF BURIAL,

July 11, 1915

20-UNDERTAKER

Lily & Feiler

ADDRESS

403 S. 10th

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86576

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86576

1-PLACE OF DEATH

1811 N. Washington St.

REGISTERED No. C

CITY OF BALTIMORE: (No.)

Caroline C.

ST.

WARD)

2-FULL NAME

Louis Lapsley

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1B.)

(Residence in Baltimore: No.)

1811 N. Washington

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widowed

6-DATE OF BIRTH

Aug. 22, 1889

7-AGE

55 yrs. 11 mos. 17 ds. or 1 day hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None.

9-BIRTHPLACE
(State or country)

Baltimore City

PARENTS

10-NAME OF FATHER

John W. Pittroff

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis Lapsley

(Address)

1811 N. Washington St.

15-

ROBERT KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 9, 1915

17- I HEREBY CERTIFY, That I attended deceased from March 12, 1915, to, July 8, 1915,

that I saw her alive on July 8, 1915, and that death occurred, on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Myocarditis
Arterio SclerosisContributory
(SECONDARY)

Left Side Hemiplegia

(Signed),

Edgar P. Sandrock M.D.

July 9, 1915. [Address] 1601 N. Broadway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Owens Ridge Cemetery

July 11, 1915

20-UNDERTAKER

ADDRESS

E J Fanning 1935 E. Frederick St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. *1635 Presbury* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*Blk.*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

December (Month) *20* (Day) *1899* (Year)

7-AGE,

15 yrs. *7* mos. *21* ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework
*Private Family*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Benjamin Milligan*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Martha Roizer*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Benjamin Milligan*(Address) *1635 Presbury St.*

15-

Filed *Jul 10 1915* *ROBERT K. KROGER,*
101 *Hospital* Permit *C. L. O. R.*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July (Month) *7* (Day) *1915* (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 30, 1915*, to *July 7, 1915*, that I saw her alive on *July 7, 1915*, and that death occurred, on the date stated above, at *11:50 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

CONTRIBUTORY

Pyelo-nephritis
Labour(Signed) *C. D. Glass* M. D.*July 7, 1915* (Address) *J. H. H.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *8* mos. *8* ds. In the State *1* yrs. *1* mos. *1* ds.Where was disease contracted, if not at place of death? *At home*Former or usual residence *1635 Presbury St.*

19-PLACE OF BURIAL OR REMOVAL,

Not in burials Cemetery

DATE OF BURIAL,

July 11th, 1915

20-UNDERTAKER

Edw. B. Pye

ADDRESS

1022 N. Liberty St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86578

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

102 C86578

1. PLACE OF DEATH

CITY OF BALTIMORE (No.

513 East

ST.: 5 WARD)

REGISTERED NO. C

2. FULL NAME

Emma Woods

(Residence in Baltimore: No.

513 East

St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Negro

5. SINGLE,

MARRIED

WIDOWED

OR DIVORCED

Married

Deceased with husband.

6. DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7. AGE

About 39

yrs.

mos.

ds.

If LESS than

1 day, hrs.

or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at Home

9. BIRTHPLACE

(State or country)

Baltimore, Md.

10. NAME OF FATHER

John Purnell

11. BIRTHPLACE OF FATHER

(State or country)

Baltimore Md.

12. MAIDEN NAME OF MOTHER

Amelia Chester

13. BIRTHPLACE OF MOTHER

(State or country)

Baltimore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ben Belcher

(Address)

513 East St.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 7

(Month)

(Day)

1915

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 2, 1915, to July 7, 1915.

that I saw her alive on July 7, 1915.

and that death occurred, on the date stated above, at 3:45 P. M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from gastric ulcer.

Contributory

(SECONDARY)

Infection

(Duration)

(Signed)

July 8, 1915

(Address)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Asbury

DATE OF BURIAL

July 11, 1915

20. UNDERTAKER

Rt. A. Elliott

ADDRESS

502 East St.

JUL 10 1915

Filed

191

JOSEPH T. KRUTER

Sup. of Health

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2005 Wilhelm* ST.; *20* WARD)

FULL NAME

(Residence in Baltimore: No. *2005 Wilhelm*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *138* yrs., *11* mos., *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

July

(Month)

24

(Day)

1864

(Year)

7-AGE,

50 yrs., *11* mos., *9* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business,
or establishment in which
employed (or employer).*Driver*
*Horn Wagon*9-BIRTHPLACE,
(State or Country),*Germany*10-NAME OF
FATHER,*Dr. Schuler*11-BIRTHPLACE
OF FATHER
(State or Country),*Germany*12-MAIDEN NAME
OF MOTHER*Unknown*13-BIRTHPLACE
OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Herminda Schuler

#

2005 Wilhelm St

15-

*JUL 10 1915*Filed *1915* *121* Permit *101*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

(Month)

9

(Day)

1915

(Year)

17 I HEREBY CERTIFY, That I attended deceased from
July 7 191*5*, to *July 9* 191*5*,
that I saw him alive on *July 8* 191*5*,
and that death occurred, on the date stated above, at *4:00* m.

The CAUSE OF DEATH* was as follows:

Emboli(Duration) *few minutes* yrs. mos. ds.CONTRIBUTORY
(Secondary)(Duration) *2* yrs. mos. ds.

(Signed)

Harold Kalia M. D.
July 9 191*5* (Address) *2027 Wood St**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Western Cemetery**July 11* 191*5*

20-UNDERTAKER

ADDRESS

F. B. Huppert 2738 Fred St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 Esplanade St. 10 WARD)2-FULL NAME Henry Melorik(Residence in Baltimore: No. 1313 Esplanade St. 10 yrs. 20 mos. 10 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Not known, 1 (Month) (Day) (Year)

7-AGE,

58 yrs. 20 mos. 10 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer
General

9-BIRTHPLACE,

(State or Country),

Hungary

10-NAME OF FATHER,

George Melorik

11-BIRTHPLACE OF FATHER

(State or Country),

Hungary

12-MAIDEN NAME OF MOTHER

Lute Turcik

13-BIRTHPLACE OF MOTHER

(State or Country),

Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Anna Melorik
1313 Esplanade

(Address)

15-

Filed

JUL 11 1915

CERT . ERATER

Special Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 10, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 15th 1914, to July 9th 1915, that I saw him alive on July 9th 1915, and that death occurred, on the date stated above, at 1:40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia in 9th
stage..... (Duration) yrs. 7 mos. 10 ds.

CONTRIBUTORY (Secondary),

Hypertension (Duration) 4 yrs. 10 mos. 10 ds.

(Signed)

Edmund J. Brown M. D.
July 10, 1915 (Address) 208 Carroll St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 20 mos. 10 ds. In the State yrs. 20 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy RedeemerJuly 13, 1915

20-UNDERTAKER

ADDRESS

Frank Crocker1847 Highland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *8*)

2-FULL NAME

(Residence in Baltimore: No. *2486 B Preston*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH

April 8

(Month)

(Day)

1867

(Year)

7-AGE,

52

yrs.

mos.

da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*advertising writer*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Geo J. Brown*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Mary Ritchard*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

W. H. H. H.

15-

JUL 11 1915

Filed

*ROBERT K. KROGER**Sup'l Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 10

(Month)

(Day)

1915

(Year)

I HEREBY CERTIFY, That I attended deceased from *June 21* 191*5*, to *July 10* 191*5*, that I saw him alive on *July 10* 191*5*, and that death occurred, on the date stated above, at *1:45 P.M.*

The CAUSE OF DEATH* was as follows:

Gall Stone in Common duct. Peritonitis.(Duration) *2* yrs. *4* mos. *4* da.CONTRIBUTORY
(Secondary)*Peritonitis*(Duration) *4* yrs. *4* mos. *4* da.(Signed) *R. D. M. C. H.* M. D.*July 11, 1915.* (Address) *J. H. H.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *14* yrs. *14* mos. *14* da. In the State *14* yrs. *14* mos. *14* da.Where was disease contracted, if not at place of death? *Home*Former or usual residence *2416 B Preston St*

19-PLACE OF BURIAL OR REMOVAL,

Belair Md.

DATE OF BURIAL,

July 12 191*5*

20-UNDERTAKER

Henry Jacob H. H.

ADDRESS

1301 E Eym

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15- Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86582

CERTIFICATE OF DEATH

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 Wellington Ave. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah M. Meade

(Residence in Baltimore: No. 806 Wellington Ave. St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH April 24 1885 (Month) (Day) (Year)

7-AGE 30 2 15 If LESS than 1 day, hrs., or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work At Home (b) General nature of industry, business, or establishment in which employed (for employer)

9-BIRTHPLACE (State or country) Balto. Co. Md.

10-NAME OF FATHER James A. Meade 11-BIRTHPLACE OF FATHER (State or country) England 12-MAIDEN NAME OF MOTHER Sarah A. Ryan 13-BIRTHPLACE OF MOTHER (State or country) Balto. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE James A. Meade (Informant) 806 Wellington Ave. (Address)

15- JUL 11 1915 [Signature] . KRAUTER, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 9th, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 20, 1916, to July 9th, 1915, that I saw her alive on July 7th, 1915, and that death occurred, on the date stated above, at 3:20 p.m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. + mos. ds. Contributory Exhaustion gradually developing (SECONDARY) (Duration) 4 mos. ds. (Signed) R. B. Krauter M. D. July 10th, 1915 [Address] 3543 Chestnut St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL ST. Mary's Govan. July 12 1915

20-UNDERTAKER ADDRESS A.S. Marshall 3539 Falls Road

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

Mersey Hospital

Genge W. Cass

201 W. Dickman St.

ST.

23

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. (yrs., 33 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH,

Sept. 10th, 1881

(Month) (Day) (Year)

7-AGE

33

10

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer
General

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

W^m Cass

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Josephine Welch

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W^m Josephine Cass

(Address)

201 W. Dickman St.

15-

JUL 11 1915

W. KAUFER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

10th

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis complicated with Cardiac Thromboses

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. M. Savage, M. D.

(Coroner.)

July 11, 1915 (Address) 1729 W. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

201 W. Dickman St.

Former or usual residence 201 W. Dickman St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill Cem.

July 13, 1915

20-UNDERTAKER

E. Schloman & Son

ADDRESS 1039

St. Lawrence St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *7* WARD)
FULL NAME *Rayton Frey*
(Residence in Baltimore: No. *821 J. St. Sparrows Pt* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Male</i>	4-COLOR OR RACE. <i>Colored</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Married</i> (Write the word.)
6-DATE OF BIRTH. <i>Unknown</i> , 18 <i>60</i> (Month) (Day) (Year)		
7-AGE. <i>55</i> yrs. mos. ds.		If LESS than 1 day, hrs. or min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Laborer.</i> (b) General nature of industry, business, or establishment in which employed (or employer). <i>General</i>		
9-BIRTHPLACE, (State or Country), <i>Va.</i>		
PARENTS.	10-NAME OF FATHER, <i>?</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Va.</i>	
	12-MAIDEN NAME OF MOTHER, <i>?</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Va.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Phelps.*
(Address) *Johns Hopkins Hosp.*

15- JUL 11 1915
ROBERT KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *July 8*, 191*5*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *July 6* 191*5*, to *July 8* 191*5*, that I saw him alive on *July 8* 191*5*, and that death occurred, on the date stated above, at *8:10 p.m.*

The CAUSE OF DEATH* was as follows:

Rupture of Aneurysm of Thoracic aorta.
(Duration) yrs. mos. ds. *10 minutes*

CONTRIBUTORY (Secondary) *Aneurysm*
(Duration) yrs. mos. ds. *Unknown*

(Signed) *Stampho Bayne - Jones, D.*
July 8, 191*5* (Address) *Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *821 J. St. Sparrows Pt*

19-PLACE OF BURIAL OR REMOVAL. *Berminston Va* DATE OF BURIAL. *July 11, 1915*

20-UNDERTAKER *Sam'l W. Chase & Son* ADDRESS *1400 Mosher*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

ST.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St., yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

IF LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-JUL 11 1915

Filed

191

ROBERT J. KRAUTER

Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Cause of death)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Carroll

(Address) 133 Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the 35

Where was disease contracted, if not at place of death?

Coca Cola Bldg.

Former or usual residence Eastern Ave Rd.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oak Lawn

July 11 1915

John A. Moran & Co.

ADDRESS Bank

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1203 N. Montford Ave. 8

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary Campanaro

(Residence in Baltimore: No.

1203 N. Montford Ave

St: 30 yrs., 11 mos., 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE.

white

5-STATUS,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

married

6-DATE OF BIRTH.

July

10

1883

(Month)

(Day)

(Year)

7-AGE.

30

11

28

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE.

(State or Country).

Maryland

10-NAME OF FATHER.

Salvator Pedone

11-BIRTHPLACE OF FATHER

(State or Country).

Italy

12-MAIDEN NAME OF MOTHER

Catherine Pinto

13-BIRTHPLACE OF MOTHER

(State or Country).

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Anna Harrihan

(Address).

1820 E. North Ave

JUL 11 1915

Filed....., 191... HOSPITAL PERMIT OFFICE
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July

8

1915.

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from July 1st 1915, to July 8th 1915, that I saw her alive on July 8th 1915, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(Duration) 0 yrs. 0 mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Marden M. D.

July 8., 1915. (Address) 2401 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Redeemer Cem.

Jul 12th 1915.

20-UNDERTAKER

ADDRESS

John A. Moran Barb James

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *36 S. Hare* ST. *1* WARD)FULL NAME *John F. Pletha*(Residence in Baltimore: No. *36 S. Hare* St.; yrs. mes. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH

unknown 18*75*
(Month) (Day) (Year)

7-AGE

35 yrs. mos. ds.If LESS than 1 day
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Tailor
mens*

9-BIRTHPLACE, (State or Country),

Ind

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John F. Pletha*(Address) *36 S. Hare St.*

15-

JUL 11 1915

Filed..... 191.....

JERRY KRAUTER

Baptist Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 9, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 26* 191*5*, to *July 9* 191*5*,
that I saw him alive on *July 9* 191*5*,
and that death occurred, on the date stated above, at *9 P.* m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) yrs. mos. ds. *13*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. *1*(Signed) *John F. Pletha* M. D.*July 11*, 191*5* (Address) *36 S. Hare St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cem.**Aug 12*, 191*5*

20-UNDERTAKER

ADDRESS

*John J. Moran**Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *58 E Heath* ST.; *23* WARD)FULL NAME *Edward Hoffman*(Residence in Baltimore: No. *58 E Heath* St.; yrs. *10* mos. *7* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

Single

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Sept 3, 1914
(Month) (Day) (Year)

7-AGE,

10 yrs. 7 mos. 7 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER,

Geo H Hoffman

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Marta Beulan

13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo Hoffman*(Address) *58 E Heath St.*

15-

JUL 11 1915

Filed

191

ROBERT K. KRAUTER,
1212 Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 10, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 3, 1915, to *July 10, 1915*,that I saw him alive on *July 10, 1915*,and that death occurred, on the date stated above, at *1 P* m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *R. A. Campbell* M. D.*July 10, 1915* (Address) *1644 S. Howard St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cemetery

DATE OF BURIAL,

July 12, 1915

20-UNDERTAKER

H. & M. L. Flynn

ADDRESS

1422 Highland St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *121 E. West* ST.; *22* WARD)

2-FULL NAME

(Residence in Baltimore: No. *121 E. West* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH.

Sept 2, 1859
(Month) (Day) (Year)

7-AGE.

55 yrs. 10 mos. 7 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Gunner

(b) General nature of industry, business, or establishment in which employed (or employer)

U. S. N.

9-BIRTHPLACE, (State or Country),

England

10-NAME OF FATHER,

Martin Murray

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Cath. Owens

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Maggie A. Murray

(Address)

121 E. West St.

15-

JUL 11 1915

ROBERT KRAUTER,

Filing Office, Baltimore, Md.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

7-10-, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *2-10* 191*5*, to *7-9-* 191*5*, that I saw him live on *7-9-* 191*5*, and that death occurred, on the date stated above, at *1 p.* m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary tuberculosis
(Duration) yrs. *6* mos. *6* ds.

CONTRIBUTORY (Secondary)

Acute Pulmonary T.B.
(Duration) yrs. *6* mos. *6* ds.
(Signed) *J. J. Murray* M. D.
7-11-1915 (Address) *1604 Linden Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral

DATE OF BURIAL,

July 13, 1915

20-UNDERTAKER

F. A. Krause

ADDRESS

703 Howard St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

14. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Clara A. Udelle
HEALTH DEPARTMENT--CITY OF BALTIMORE
CERTIFICATE OF DEATH

C86590

170 C86590
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 N Fulton Ave ST. 15 WARD)

2-FULL NAME

Clara A. Udelle

(If death occurred in a hospital or institution, give its NAME instead of street and number and room No. 18.)

(Residence in Baltimore: No. 1812 N Fulton Ave

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

6-DATE OF BIRTH

June

1852

7-AGE

63

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

at home

9-BIRTHPLACE
(State or country)

Pa

10-NAME OF FATHER

Haram Lambert

11-BIRTHPLACE OF FATHER
(State or country)

Pa

12-MAIDEN NAME OF MOTHER

Susan Dutton

13-BIRTHPLACE OF MOTHER
(State or country)

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

a. G. Udelle

(Address)

1812 N Fulton Ave

15-

JUL 11 1915

RECEIVED . KRAUTER,
Baptist Permit Clerk

RECEIVED

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 9, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
April 10, 1915, to, July 9, 1915,

that I saw him alive on July 9, 1915,

and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.
Contributory Chronic Myocarditis
(SECONDARY)

(Duration) 3 yrs. mos. ds.

(Signed) Franklin H. Erb M.D.

July 10, 1915 [Address] 1735 V. Mallory Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

July 12, 1915

20-UNDERTAKER

F. A. Vance

ADDRESS

703 Honored

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2917 Parkwood Ave ST. 13 WARD)2-FULL NAME Thomas R Bayley(Residence in Baltimore: No. 2917 Parkwood Ave St.; 13 yrs., 1 mos., 1 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male4-COLOR OR RACE, White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, July 3, 1843

(Month)

(Day)

(Year)

7-AGE 72yrs., 1 mos., 1 ds.If LESS than 1 day, 43 hrs. or 15 min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Letter Carrier
(b) General nature of industry, business, or establishment in which employed (or employer), U.S.9-BIRTHPLACE, (State or Country), Ind10-NAME OF FATHER, Hamilton Bayley11-BIRTHPLACE OF FATHER (State or Country), Don't know12-MAIDEN NAME OF MOTHER Mary Anna Bercester13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosalie M Bayley(Address) 2917 Parkwood

15-

JUL 11 1915

ROBERT KRAUTER,

Filed 101 Serial 101 Permit 101 Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4, 1914 to July 9, 1915that I saw him alive on July 9, 1915 and that death occurred, on the date stated above, at 435 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease
about 5
(Duration) 5 yrs., 1 mos., 1 ds.

CONTRIBUTORY (Secondary)

(Signed) Michael Garb M. D.
July 10, 1915 (Address) 2731 Parkwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 1 yrs., 1 mos., 1 ds. In the State 1 yrs., 1 mos., 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New CathedralDATE OF BURIAL, June 13, 191520-UNDERTAKER William CookADDRESS 602 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information must be carefully supplied. Not more than one name should be given for each item. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Louis Kaplan
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY *8* BALTIMORE (No. *702 W. Lombard* St.: *4* WARD)
FULL NAME *Louis Kaplan*
Residence in Baltimore: No. *702 W. Lombard* St.: yrs. *25* mos. *—* ds.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-STATUS, *Married*
6-DATE OF BIRTH, *Unknown*, 1
7-AGE, *64* yrs. *—* mos. *—* ds. 10-LESS than 1 day, *—* hrs. or *—* min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Cigar Merchant*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Russia*
PARENTS.
10-NAME OF FATHER, *Hyman Kaplan*
11-BIRTHPLACE OF FATHER, (State or Country), *Russia*
12-MAIDEN NAME OF MOTHER, *Unknown*
13-BIRTHPLACE OF MOTHER, (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *H. Kaplan*
(Address) *702 W. Lombard St.*

15-*JUL 12 1915* HARRY O. ADAMS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, *July 11*, 191*5*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Distention

CONTRIBUTORY (Secondary) *Org. heart disease*

(Signed) *J. J. Jeffers* M. D.
July 11, 1915 (Address) *413 N. Carroll St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL, *Hebrew Burial*

DATE OF BURIAL, *July 12*, 191*5*

UNDERTAKER, *J. Ginnison & Bro*

ADDRESS *1107 E. Balto St.*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (NO. 442 N Gay ST. 5 WARD)

2-FULL NAME Sophie Omausky

Residence in Baltimore: No. 442 N Gay St. 7 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH May 15 1856

7-AGE 59 yrs. 1 mos. 27 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE (State or country) Russia

10-NAME OF FATHER Joseph Omausky

11-BIRTHPLACE OF FATHER (State or country) Russia

12-MAIDEN NAME OF MOTHER Janofsky

13-BIRTHPLACE OF MOTHER (State or country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry O. Andrews

(Address) 442 N Gay St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 12 1915

17- I HEREBY CERTIFY That I attended deceased from July 8, 1915, to July 12, 1915, that I saw her alive on July 12, 1915, and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

Contributory (SECONDARY) Mitral Regurgitation

(Signed) A. J. Baylin

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 442 N Gay St.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

JUL 12 1915

HARRY O. ANDREWS, MARIAL POSE REGISTRAR

Refused Mt Carmel July 12 1915
J. Linnam & Bro Balto St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86594

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1926 McCulloh* ST.: *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Regina Ashby*(Residence in Baltimore: No. *1926 McCulloh* St.: — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Colored*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Unknown*, 1.....

(Month)

(Day)

(Year)

7-AGE, *54* yrs., — mos., — ds.

If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION: *Domestic*

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... *Private family*9-BIRTHPLACE, (State or Country), *Ind*10-NAME OF FATHER, *Douglas Brown*11-BIRTHPLACE OF FATHER (State or Country), *Ind*12-MAIDEN NAME OF MOTHER *Regina Reed*13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Ashby*(Address) *1926 McCulloh*

15-

Filed

JUL 12 1915

HARRY O. ANDREWS,

Bureau Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 10*, 1915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 5*, 1915, to *July 8*, 1915,that I saw him alive on *July 8*, 1915,and that death occurred, on the date stated above, at *1:30 a.m.*

The CAUSE OF DEATH* was as follows:

*Chronic Paucity of blood
toxic nephritis*..... *about*.....
(Duration)..... yrs. mos. ds.CONTRIBUTORY (Secondary) *General debility*

..... (Duration)..... yrs. mos. ds.

(Signed) *James Ashby* M. D.*July 10* 1915 (Address) *1019 Dumbarton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Paul's*DATE OF BURIAL, *July 13*, 191520-UNDERTAKER *James Ashby*ADDRESS *1364 Mary*

CAUSE OF DEATH in plain text, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

13. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86593

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C.

PLACE OF DEATH

CITY OF BALTIMORE (No. 54 N. Caroline

ST.

WARD)

2-FULL NAME

Eva Vogelwald

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. 54 N. Caroline

St.; yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, 7-AGE, If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER (State or Country), 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) George Vogelwald (Address) 54 N. Caroline

15- JUL 12 1915. HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows:

Natural Causes

CONTRIBUTORY (Secondary) Intermittent & Acute

(Signed) Elyah Russell, M. D. (Coroner.) July 11, 1915 (Address) 423 N. Pennsylvania

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death... yrs... mos... ds. In the State... yrs... mos... ds. Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

St. Mathewas Cem. July 12 1915. Philip Herwig Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1241 S. Secker ave* ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1241 S. Secker ave* St.;

yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Single*

6-DATE OF BIRTH,

July 10, 1915
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day.

yrs. mos. ds. *24 hrs. or min.*

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work..... *None*

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Maryland*

10-NAME OF

FATHER, *Theo Kaszazak*

11-BIRTHPLACE

OF FATHER (State or Country), *Austria*

12-MAIDEN NAME

OF MOTHER *Kath. Brzozko*

13-BIRTHPLACE

OF MOTHER (State or Country), *Austria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Theodore Kaszazak*(Address) *1241 S. Secker ave*

15-

JUL 12 1915 HARRY O. ANDREWS,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 11, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

July 10, 1915 to *July 11, 1915*that I saw him alive on *July 10, 1915*

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

6 month Foetus

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. B. Sullivan* M. D.*July 12, 1915* (Address) *713 S. O'Donnell*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

H. Stanislaus

DATE OF BURIAL,

July 12, 1915

20-UNDERTAKER

M. J. Sudowski

ADDRESS

705 S. Ann St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86597

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86597

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1012 Carrollton Ave* ST. *16* WARD)

2-FULL NAME *Frank E. Newman*

Residence in Baltimore: No. *1012 Carrollton Ave* St. *16* yrs. *6* mos. *16* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Caucasian

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

Jun 24, 1915

(Month) (Day) (Year)

7-AGE

6 yrs. *16* mos. *16* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Bal to

10-NAME OF FATHER

Frank Newman

11-BIRTHPLACE OF FATHER (State or country)

Va

12-MAIDEN NAME OF MOTHER

Florence Tate

13-BIRTHPLACE OF MOTHER (State or country)

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Newman

(Address)

1012 N. Carrollton Ave

15.

JUL 12 1915

HARRY O. ANDREWS,

BALTIMORE HEALTH DEPARTMENT

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 10, 1915

17. I HEREBY CERTIFY, That I attended deceased from *July 9, 1915* to *July 10, 1915*, that I saw him alive on *July 10, 1915*, and that death occurred, on the date stated above, at *11:30* m. The CAUSE OF DEATH* was as follows:

Diarrhoea Enteritis

Contributory (SECONDARY)

(Signed)

Walter A. Cox M. D.

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death: yrs. mos. ds. In the State: yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence:

19-PLACE OF BURIAL OR REMOVAL

Mt. Auburn

DATE OF BURIAL

July 12, 1915

20-UNDERTAKER

Sam'l H. Chase & Son

ADDRESS

2400 Mosier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86598

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

C86598

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE (No.

2. FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. JUL 12 1915

DANIEL O. ANDERSON,
Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed) M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

C86599

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86599

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *304 Forrest St.* ST. *5* WARD)
*FULL NAME *Bessie Swann*
(Residence in Baltimore: No. *304 Forrest St.*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *10* mos. *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)
6-DATE OF BIRTH. *August 12, 1918*
(Month) (Day) (Year)
7-AGE. *10* yrs. *28* mos. *28* ds. IT LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Child*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country), *City*

10-NAME OF FATHER. *George W. Swann*
11-BIRTHPLACE OF FATHER (State or Country), *City*
12-MAIDEN NAME OF MOTHER. *Louisa Puffus*
13-BIRTHPLACE OF MOTHER (State or Country), *City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louisa Swann*
(Address) *304 Forrest St.*

15- *JUL 12 1915* HARRY C. ANDREWS, Registrar.
Filed *101*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *July 10, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

and that said deceased came to *death* (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) *1* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary) *Auto Bronchitis*

(Duration) *1* yrs. *1* mos. *1* ds.

Signed) *Thos. H. Chambers* M. D.
(Coroner.)

July 10, 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. *1* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL. *2440 Euc* DATE OF BURIAL. *JUL 12 1915*

20-UNDERTAKER *R. E. Liott* ADDRESS *506 S. Gay St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *854 Ostend* ST.; *21* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME *Roland Sanders*(Residence in Baltimore: No. *854 Ostend St.* St.; yrs. *4* mon. *22* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE,

*colored*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

*Feb**19**1915*

(Month)

(Day)

(Year)

7-AGE,

4 yrs. *22* mos. *22* da.

IF LESS than 1 day.

...hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),*Baltimore Md*

PARENTS.

10-NAME OF FATHER,

*Tennysen Sanders*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore Md*

12-MAIDEN NAME OF MOTHER

*Edna Cyren*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edna Sanders*(Address) *854 Ostend St.*

JUL 12 1915

Filed.....

191

Burial Permit *Glory*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July *11* *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 10 1915, to *July 11 1915*,that I saw him alive on *July 10 1915*,and that death occurred, on the date stated above, at *12:54* m.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration).....yrs.....mos.....da.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....da.

(Signed) *Theresa Drain* M. D......, 101... (Address) *1237 Columbia St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Auburn St

DATE OF BURIAL,

July 12, 1915

20-UNDERTAKER

John Brown & Son

ADDRESS,

108 W. Mont St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86601

CERTIFICATE OF DEATH.

64

C86601

1-PLACE OF DEATH

University Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Richard Stidham

(Residence in Baltimore: No.

713 N. Stricker St.

St.; 76 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widowed

6-DATE OF BIRTH.

November 1839

(Month)

(Day)

(Year)

7-AGE,

76

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer).

General

9-BIRTHPLACE,

(State or Country),

Maryland (City)

10-NAME OF FATHER,

Richard Stidham

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Miss Stidham

(Address)

713 N. Stricker St.

15-

JUL 12 1915

HARRY O. ANDREWS,

Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 10, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

5/31 1915, to July 10 1915,

that I saw him alive on July 10 1915,

and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Myocardial (residual) ...
 Cerebral softening - Senility ...
 (Duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary)

None

(Duration) 7 yrs. mos. ds.

(Signed)

W. Stidham M. D.

July 10, 1915. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 11 ds. In the State unknown

Where was disease contracted, if not at place of death? Unknown

Former or usual residence

713 N. Stricker St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cemetery July 13 1915

20-UNDERTAKER

ADDRESS

Mrs. A. Rohde 730 P. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

086602

CERTIFICATE OF DEATH

42 086602
REGISTERED No. C

1-PLACE OF DEATH

2-CITY OF BALTIMORE (No.

3-FULL NAME

(Residence in Baltimore: No.

119 S. Linwood Ave

Elizabeth C. Nitzel

119 S. Linwood Ave

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

55 yrs. 11 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, ~~MARRIED~~ Single (Write the word)

6-DATE OF BIRTH July 30, 1859 (Month) (Day) (Year)

7-AGE 55 yrs. 11 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housekeeper

9-BIRTHPLACE (State or country) Baltimore Md

10-NAME OF FATHER John J. Nitzel

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Margaret Meyer

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Henry Nitzel (Address) 119 S. Linwood Ave

15 JUL 12 1915. HARRY O. ANDREWS, Registrar Filed 191

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 10, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 21, 1915, to July 10, 1915, that I saw her alive on July 8, 1915, and that death occurred, on the date stated above, at 9:30 P. M. The CAUSE OF DEATH* was as follows:

Carcinoma Uterus (Duration) yrs. 19 ds

Contributory Phlebotomy Liver - Ascites (SECONDARY)

(Signed) C. N. O'Keefe July 11, 1915 (Address) 1005 Patten Pl. M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St Paul's Luth Cemetery DATE OF BURIAL July 13, 1915

20-UNDERTAKER Mrs A Rohde Son ADDRESS 730 Pa Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infirmary* ST. *14* WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Rita Alexander*(Residence in Baltimore: No. *St. Vincent's Infirmary* St.: yrs. *3* mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

6-DATE OF BIRTH,

January 29, 1915
(Month) (Day) (Year)

7-AGE,

5 yrs. 5 mos. 10 da.

If LESS than 1 day,

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

England

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUL 12 1915

HARRY O. JENKINS,

Filing

191

BALTIMORE, MD.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 9, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 3, 1915, to July 9, 1915,*that I saw her alive on *July 9, 1915,*and that death occurred, on the date stated above, at *11:00 a. m.*

The CAUSE OF DEATH* was as follows:

Gastro-intestinal intoxication(Duration) yrs. mos. *6* da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) *J. P. Poulson* M. D.*July 9, 1915* (Address) *615 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *3* mos. *5* da. In the State yrs. *5* mos. *10* da.Where was disease contracted, if not at place of death? *St. Vincent's Infirmary*Former or usual residence *St. Vincent's Infirmary*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral July 2, 1915

20-UNDERTAKER

ADDRESS

M. Fraher & Sons 601 Zepher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86604

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86604

CERTIFICATE OF DEATH.

64

PLACE OF DEATH

CITY OF BALTIMORE (No

2-FULL NAME

Residence in Baltimore: No.

907 Warner

John W. Williams

907 Warner

ST. 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St. yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

Married

6-DATE OF BIRTH

October 1, 1859

7-AGE,

56

Yrs. — mos. — ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer
General

9-BIRTHPLACE,

(State or Country)

Ind.

10-NAME OF FATHER

Samuel Williams

11-BIRTHPLACE OF FATHER

(State or Country)

Ind.

12-MAIDEN NAME OF MOTHER

Nancy Williams

13-BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Isabella Williams

(Address)

907 Warner

15

JUL 12 1915.

Filed

191

HARRY O. ANDREWS,

Serial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH

July 9, 1915

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Apoplexy

(Duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. — mos. — ds.

(Signed) John Greenleaf M. D.

(Coroner.)

July 10, 1915. (Address) St. 17 South St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Ambrose

July 12, 1915

20-UNDERTAKER

ADDRESS

Charles Keeshy

5800 Bridge

C86605

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86605

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *21* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Odo Blake*(Residence in Baltimore: No. *212 Otterbein St.* St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*Colored.*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

July 8, 1901
(Month) (Day) (Year)

7-AGE,

14 yrs. — mos. — ds.

If LESS than 1 day,

— hrs. or — min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House work.
*none*9-BIRTHPLACE,
(State or Country),*Maryland.*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUL 12 1915

HARRY O. ANDERSON

Filed....., 1915

Marital Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 9, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 8, 1915*, to *July 9, 1915*, that I saw her alive on *July 9, 1915*, and that death occurred, on the date stated above, at *8:15 P.M.*

The CAUSE OF DEATH* was as follows:

Epilepsy, and 12/24/31
Regen. Burns, Face, Hands, Feet

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)*Acute primary Sepsis*
Uremia (Duration)..... yrs..... mos..... ds.(Signed) *Edgar M. Newcomb, M.D.**July 10, 1915* (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence *212 Otterbein St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*HOPKINS HOSPITAL**June 19, 1915*

20-UNDERTAKER

Commissioner Health,

ADDRESS

Wm. E. WOODBALL

FOR ANATOMICAL PURPOSES.

Caution of death in print form, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86606

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 E. Baltimore St.; 1 WARD)

FULL NAME Mary E. Dorsey

(Residence in Baltimore: No. 2223 E. Baltimore St.;

yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) MARRIED

6-DATE OF BIRTH, Nov. 28, 1873

(Month)

(Day)

(Year)

7-AGE, 41

yrs.

7 mos.

da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, at home

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md

10-NAME OF FATHER, Fred. F. Dorsey

11-BIRTHPLACE OF FATHER, Germany

12-MAIDEN NAME OF MOTHER, Catherine Farnum

13-BIRTHPLACE OF MOTHER, Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Mary E. Dorsey

(Address), 2223 E. Baltimore St.

15-

JUL 12 1915.

Filed

191

HARRY O. ANDERSON, Marital Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

1910, to July 9, 1915

that I saw her alive on July 9, 1915

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(Duration) 5 yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed) John P. Spickard, M. D.

July 10, 1915 (Address) 2122 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Wood Lawn

DATE OF BURIAL, July 12, 1915

20-UNDERTAKER, H. Sander & Sons

ADDRESS, 1708 Park St.

CAUSE OF DEATH in plain text, as that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86607

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86607

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

Hebrew Hospital

ST. 7

WARD

2-FULL NAME

Clara Roever

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No.

334 S. Highland Ave

St.

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widow

6-DATE OF BIRTH

not known, 1875

7-AGE

46

yrs.

mos.

ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

house work
None
at home

9-BIRTHPLACE
(State or country)

U.S.A. - Md

10-NAME OF
FATHER

not known

11-BIRTHPLACE
OF FATHER
(State or country)

Germany

12-MAIDEN NAME
OF MOTHER

not known

13-BIRTHPLACE
OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma C. Fiske
334 S. Highland Ave

JUL 12 1915

HARRY O. ANDREWS

Filed

191

Serial Permit 0101

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 11, 1915

17- I HEREBY CERTIFY, That I attended deceased from
July 3, 1915, to July 11, 1915.
that I saw her alive on July 11, 1915.
and that death occurred, on the date stated above, at 8:55 P. m.

The CAUSE OF DEATH* was as follows:
Typhoid Septicemia

Contributory
(SECONDARY)

(Duration) yrs. mos. ds. 14

(Signed)

M. B. Roever

M. D.

7/11, 1915 (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 9 ds. State 40 yrs. mos. ds.
Where was disease contracted, 115 S. Boulevard
If not at place of death? 115 S. Boulevard
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Evangelical

DATE OF BURIAL

July 14, 1915

20-UNDERTAKER

H. Sanders & Son

ADDRESS

1717 Rut St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *609 S. Port* ST. *1* WARD)2-FULL NAME *Lillian A. Fischer*(Residence in Baltimore: No. *609 S. Port* St. *1* rs. *1* mos. *1* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Dec. 1, 1880*

(Month)

(Day)

(Year)

7-AGE, *34* yrs. *7* mos. *10* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country), *Balto City M.d.*10-NAME OF FATHER, *Louis Morr*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Eliz. Bringer*13-BIRTHPLACE OF MOTHER (State or Country), *Balto City M.d.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John E. Fischer*(Address) *609 S. Port St.*

15-

Filed

*JUL 12 1915.**HARRY O. ARDREWS,**Permit. Oler.*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 11, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct 1914* to *July 9 1915*that I saw him alive on *July 9 1915*and that death occurred, on the date stated above, at *3:30 p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration)yrs. *9* mos.ds.

CONTRIBUTORY (Secondary)

(Duration)yrs.mos.ds.

(Signed) *Walter H. Thomas* M. D.*July 12 1915* (Address) *1225 N. Caroline*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Connel*DATE OF BURIAL, *July 12, 1915*20-UNDERTAKER *16 Sander & Jane*ADDRESS *1710 E. 1st St.*

Caution of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86609

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86609

CERTIFICATE OF DEATH

104 REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 N. Eden St. 5 WARD)

2-FULL NAME

Esther L. Harris
304 N. Eden St.

(Residence in Baltimore: No. 304 N. Eden St. 6 mos. 2 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Infant

6-DATE OF BIRTH

Nov. 22nd 1914

7-AGE

6 mos. 21 ds. or 1 day, hrs. min.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Balto Md.

10-NAME OF FATHER

Chas. Harris

11-BIRTHPLACE OF FATHER
(State or country)

Balto

12-MAIDEN NAME OF MOTHER

Gertrude Woods

13-BIRTHPLACE OF MOTHER
(State or country)

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gertrude Harris
304 N. Eden St

15-

File

191

HARRY O. ANDREWS

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 12, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 7, 1915, to July 12, 1915

that I saw him alive on July 12, 1915,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

Contributory
(SECONDARY)

(Signed)

W. E. Harris
July 12, 1915 [Address] 1466 Myerson St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Laurel Green

DATE OF BURIAL

July 15th 1915

20-UNDERTAKER

Harry A. Goddard 1725 Orleans St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86610

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C.

CITY OF BALTIMORE: (No.

St.:

WARD)

2-FULL NAME

Mary Gray
Little Sisters of the Poor

(Residence in Baltimore: No.

St.:

Yrs.

Mos.

Ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and full set No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widow

6-DATE OF BIRTH

Oct

(Month)

27

(Day)

1852

(Year)

7-AGE

63

Yrs.

8

Mos.

13

Ds.

If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE

(State or country)

Ireland

10-NAME OF FATHER

Michael Phelan

11-BIRTHPLACE OF FATHER

Ireland

12-MAIDEN NAME OF MOTHER

Bridget Hines

13-BIRTHPLACE OF MOTHER

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Superior Benedict

(Address)

Little Sisters of the Poor

15-

JUL 12 1915

HARRY O. ARTHUR

Filed

191

Special Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 10

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

No record

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pneumonia

Contributory (SECONDARY)

(Signed)

W. Warner

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *2* yrs. *10* mos. *10* ds. In the State *10* yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death? *Little Sisters of the Poor*

Former or usual residence *Little Sisters of the Poor*

19-PLACE OF BURIAL OR REMOVAL

New Cathedral

DATE OF BURIAL

July 10

20-UNDERTAKER

John J. Field 1700 W. Lombard

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86611

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

170

C86611

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1320 N Lombard St. 19 WARD)
2-FULL NAME Louisa, Eliza Duke
(Residence in Baltimore: No. 1320 N Lombard St.; ... yrs. ... mos. ... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX <u>Female</u>	4-COLOR OR RACE <u>White</u>	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>widow</u>
6-DATE OF BIRTH <u>Oct</u> (Month) <u>20</u> (Day) <u>1835</u> (Year)		
7-AGE <u>80</u> yrs. ... mos. ... ds. or min.? If LESS than 1 day, ... hrs.		
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Housewife</u>		
9-BIRTHPLACE (State or country) <u>Penn</u>		
PARENTS	10-NAME OF FATHER <u>Isador Duke</u>	
	11-BIRTHPLACE OF FATHER (State or country) <u>Penn</u>	
	12-MAIDEN NAME OF MOTHER <u>Cosa Wolf</u>	
	13-BIRTHPLACE OF MOTHER (State or country) <u>Penn</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Michael Gauer
(Address) 1320 N. Lombard

15-
JUL 12 1915
HARRY O. ANDREWS,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
July 12, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1915, to July 12, 1915, that I saw her alive on July 11, 1915, and that death occurred, on the date stated above, at 4 p.m.
The CAUSE OF DEATH* was as follows:
thrombotic infarction of the brain
(Duration) 1 yrs. ... mos. ... ds.

Contributory (SECONDARY)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. ... M. D.
7/12/15 [Address] ...

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?
Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL <u>Garden Park</u>	DATE OF BURIAL <u>July 14, 1915</u>
20-UNDERTAKER <u>John H. ...</u>	ADDRESS <u>1200 N. Lombard</u>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86612

151

C86612

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1431 McCulloh* ST. *14* WARD)

2 FULL NAME *Infant of Alice E. & Howard Ellsworth Hornum*

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 13.)

Residence in Baltimore: No. *1431 McCulloh* St. yrs. *2* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *Female*

4 COLOR OR RACE *White*

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) *Single*

16 DATE OF DEATH *July 10, 1915*

6 DATE OF BIRTH *July 10, 1915*

7 AGE

If LESS than 1 day, 9 hrs. or — mos. ?

17. I HEREBY CERTIFY, That I attended deceased from *July 10^{10.00}*, 1915, to *July 10^{7.00}*, 1915, that I saw her alive on *July 10^{6.55}*, 1915, and that death occurred, on the date stated above, at *7 P* m. The CAUSE OF DEATH* was as follows:

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Law vitality 9 hours.

9 BIRTHPLACE (State or country) *Baltimore Md.*

Contributory (SECONDARY)

Premature Birth (6^{1/2} mos.)

PARENTS

10 NAME OF FATHER *Howard Ellsworth Hornum*

11 BIRTHPLACE OF FATHER (State or country) *Baltimore Md.*

12 MAIDEN NAME OF MOTHER *Alice E. Rodgers*

13 BIRTHPLACE OF MOTHER (State or country) *Pittsburgh Pa.*

(Signed) *Dr. Caspari* M. D.

July 10, 1915 (Address) *1603 Madison Ave*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Eunice M. M. R. M.*

(Address) *537 E 21st Street City*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Western Ave*

DATE OF BURIAL *July 12, 1915*

20 UNDERTAKER *William Cook*

ADDRESS *502 E North Ave*

15 JUL 12 1915

HARRY O. ANDREWS,

REGISTRAR

C86613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 C86613

1-PLACE OF DEATH
 CITY OF BALTIMORE: (No. *Mercy Hospital* ST.; *8* WARD)
 2-FULL NAME *Marie Shinkler*
 (Residence in Baltimore: No. *1845 Chester St.* St.; *9* yrs., *7* mo., *10* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
 6-DATE OF BIRTH. *Nov 30*, 1905
 (Month) (Day) (Year)
 7-AGE. *9* yrs., *7* mo., *10* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *none*
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Md (city)*

PARENTS.
 10-NAME OF FATHER, *Valentine J. Winkler*
 11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*
 12-MAIDEN NAME OF MOTHER, *Margaret Brown*
 13-BIRTHPLACE OF MOTHER (State or Country), *Balto County*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *Valentine J. Winkler*
 (Address) *1845 Chester St.*

15-
 Filed *JUL 12 1915* 1915 HARRY O. ANDERSON
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 11*, 1915.
 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *July 9*, 1915, to *July 11*, 1915, that I saw him alive on *July 11*, 1915, and that death occurred, on the date stated above, at *2.55 p.m.*

The CAUSE OF DEATH* was as follows:

Cholera
 (Duration)..... yrs. mo. ds.

CONTRIBUTORY (Secondary) *Acute Corrosive*

(Signed) *Edward J. Smith* M. D.
July 12, 1915 (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *0* mo. *2* ds. In the *Life* State *MD* yrs. mo. ds.

Where was disease contracted, if not at place of death? *1845 Chester St.*

Former or usual residence *1845 Chester St.*

19-PLACE OF BURIAL OR REMOVAL, *St. Joseph's Church* DATE OF BURIAL, *July 12*, 1915.

20-UNDERTAKER *Marianne Cook* ADDRESS *1845 Chester St.*

Causes of death in plain terms, in that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *1* WARD)

2-FULL NAME

Residence in Baltimore: No. *600 S. Sturges St.* St. *9* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)

6-DATE OF BIRTH. *Dec 15, 1891*
(Month) (Day) (Year)

7-AGE. *(23) 23* yrs. *6* mos. *25* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Baker*
(b) General nature of industry, business, or establishment in which employed (or employer) *"*

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *John Paiper*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *Annie*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant, *Mercy Hospital*)(Address) *Calvert St.*

15. JUL 12 1915

Filed....., 1915. HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *July 10, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *July 10, 1915* to *July 10, 1915*, that I saw him alive on *July 10, 1915* and that death occurred on the date stated above, at *7:50* m.

The CAUSE OF DEATH* was as follows:

*Perforated Ulcer**Do not know*
(Duration) yrs. mos. ds.CONTRIBUTORY *Surgical Shock*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Edward J. Smith* M. D.*July 10, 1915* (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSFERS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds. *Do not know*Where was disease contracted, if not at place of death? *600 S. Sturges St*Former or usual residence *600 S. Sturges St*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Trinity Church 1915

20-UNDERTAKER ADDRESS

William Cook 502 E. North

Correct of entries in print form, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

30

C86615

PLACE OF DEATH

CITY OF BALTIMORE (No.

St. Joseph Hospital 6

REGISTERED NO. C

WARD)

FULL NAME

Margaret Schilling -

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

112 North Hare

St.; yrs. - mo. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 12, 1905
(Month) (Day) (Year)

7-AGE,

12 yrs. 28 mos. ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....Child
School9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF
FATHER,

John C. Schilling

11-BIRTHPLACE
OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME
OF MOTHER

Elena J. Turner

13-BIRTHPLACE
OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

John C. Schilling
112 N. Hare St.

15-

JUL 12 1915

HARRY O. ANDREWS,

Filed.....

191

BALTIMORE CITY
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 10, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 6 1915, to July 10 1915,

that I saw her alive on July 10 1915,

and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis -

(Duration)..... yrs. 7 mos. ds.

CONTRIBUTORY.....
(Secondary).....
Tubercular Branch

(Duration)..... yrs. 1 mos. ds.

(Signed)..... M. D.

July 10, 1915. (Address) St. Joseph's Hos.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
FERS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State of Life mos. ds.

Where was disease contracted, if not at place of death? not known -

Former or usual residence 112 N. Hare St.

19-PLACE OF BURIAL OR REMOVAL,

Cathartown

DATE OF BURIAL,

....., 191...

20-UNDERTAKER

William Cook

ADDRESS

112 N. Hare St.

Cause of death in plain terms, as that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *302 N. Stricker* ST.; *19* WARD)FULL NAME *Louise M. Bartz*(Residence in Baltimore: No. *302 N. Stricker*

REGISTERED NO. C.

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St.; *Lifetime* yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *June 22nd*, 1869 (Month) (Day) (Year)7-AGE, *46* yrs., *18* mos., *18* ds. If LESS than 1 day,hrs. or....min.8-OCCUPATION: (a) Trade, profession, or particular kind of work. *House Duties* (b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Baltimore Md.*10-NAME OF FATHER, *Daniel Bartz*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *Hora Scherb.*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louise Bartz* (Address) *302 N. Stricker St.*15- Filed *JUL 12 1915* 191... HARRY O. ANDREWS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 10th*, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1*, 1914, to *July 9*, 1915, that I saw her alive on *July 9*, 1915, and that death occurred, on the date stated above, at *8 P. M.*

The CAUSE OF DEATH* was as follows:

Cancer of stomach. (Clinical Diagnosis) (Duration) *2* yrs., mos., ds.CONTRIBUTORY *Paralysis* (Secondary) (Duration) *3* yrs., mos., ds.(Signed) *E. H. Dick* M. D. *July 10, 1915* (Address) *14 W. Monroe St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Linden Park Cemetery* DATE OF BURIAL, *July 13th*, 1915.20-UNDERTAKER, *John H. Peifer* ADDRESS, *14 W. Monroe St.*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

86617
 PLACE OF DEATH
 CITY BALTIMORE: (No. 13 Lohrs Lane ST.; 20 WARD)
 FULL NAME Frederick Zimmerman
 (Residence in Baltimore: No. 13 Lohrs Lane St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. male 4-COLOR OR RACE. white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married
 6-DATE OF BIRTH. May 29, 1856
 (Month) (Day) (Year)
 7-AGE. 59 yrs. 1 mos. 12 ds. If LESS than 1 day,hrs. or....min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. Cigar Maker
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md
 10-NAME OF FATHER, Charles Zimmerman
 11-BIRTHPLACE OF FATHER (State or Country), Germany
 12-MAIDEN NAME OF MOTHER Don't know
 13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) Anna Zimmerman
 (Address) 13 Lohrs Lane

15-
JUL 12 1915 HARRY O. ANDERSON
 Filed 1915 REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 11, 1915
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 1, 1915, to July 11, 1915, that I saw him alive on July 11, 1915, and that death occurred, on the date stated above, at 8:30 P. m.
 The CAUSE OF DEATH* was as follows:

Carcinoma of Face
(Operation 7 years previous)
 (Duration) 7 yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) 7 yrs. 1 mos. 12 ds.
 (Signed) Howard W. Jones M. D.
July 12, 1915 (Address) Demington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Linden Park July 12, 1915

20-UNDERTAKER ADDRESS

William Cook 505 E. North

Correct or insert in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *3417 Chestnut Ave* ST. *13* WARD)

FULL NAME

Bethel C. Little(Residence in Baltimore: No. *3417 Chestnut Ave*

St.: — yrs., — mon. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

April 7, 1931

(Month)

(Day)

(Year)

7-AGE,

84

yrs.

3

mos.

4

ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired Oyster Dealer

9-BIRTHPLACE, (State or Country),

Virginia

10-NAME OF FATHER,

Don't Know

11-BIRTHPLACE OF FATHER (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Don't Know

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Alice Little*(Address) *3417 Chestnut Ave*

15-JUL 12 1915

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 11, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 15 1915, to *July 11 1915*,that I saw him alive on *July 11 1915*,and that death occurred, on the date stated above, at *7:30 pm.*

The CAUSE OF DEATH* was as follows:

*Arterio sclerosis et
Senile Dementia**Indefinite* (Duration)..... yrs. mos. ds.CONTRIBUTORY. *Exhaustion*

(Secondary) (Duration)..... yrs. mos. ds.

(Signed) *W. H. Smith* M. D.*July 12, 1915* (Address) *B. & O. S. Chestnut Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Marys Cemetery *July 12, 1915*20-UNDERTAKER *William Cook* ADDRESS *502 E. North Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____)

2-FULL NAME

(Residence in Baltimore: No. _____)

REGISTERED NO. C _____

WARD) _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; _____ yrs. _____ mos. _____ da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, _____ hrs. or _____ min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) _____

(Address) _____

15-

JUL 12 1915.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on _____, 1915, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

infectious arthritis
Dnp - rt.

(Duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ da.

Signed) _____ M. D.
July 11 1915 (Address) _____

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death _____ yrs. _____ mos. _____ da. In the _____ State _____ yrs. _____ mos. _____ da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 E Baltimore St.; 6 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2212 E Baltimore St.; 60 yrs., — mos., — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, Feb 11 th, 1832
(Month) (Day) (Year)7-AGE, 83 yrs., 4 mos., 29 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), Scotland10-NAME OF FATHER, John Patterson11-BIRTHPLACE OF FATHER (State or Country), Ireland12-MAIDEN NAME OF MOTHER Elin Easton13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Russell(Address) 2212 E Baltimore

15- JUL 12 1915.

Filed....., 191.....
HARRY O. ANDREWS,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7 th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 7 1915, to July 10 1915, that I saw her alive on July 9 1915, and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Insufficiency..... (Duration) yrs. mos. 2 1/2 ds.CONTRIBUTORY (Secondary) Chronic Bronchitis..... (Duration) yrs. mos. 1 ds.(Signed) Arthur H. DeB... M. D.July 12, 1915. (Address) 201 E Pratt St

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New CathedralDATE OF BURIAL, July 13, 191520-UNDERTAKER John A. MoranADDRESS Bank

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

30
REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 E Preston

ST.: 9 WARD)

FULL NAME

Mary Ada Dawson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

(Residence in Baltimore: No. 814 E Preston

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Single

6-DATE OF BIRTH,

March 20, 1882
(Month) (Day) (Year)

7-AGE,

33 yrs. 3 mos. 21 ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

America Balto Md.

10-NAME OF FATHER,

John Dawson

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Mary Cumby

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Catherine Dawson

(Address)... 818 E Preston St.

15-

JUL 12 1915

Filed

191

Special Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 11, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 2 1915, to July 11 1915,

that I saw her alive on July 11 1915,

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Pennington M. D.

July 12 1915 (Address) 740 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral

July 13 1915

20-UNDERTAKER

ADDRESS

H. C. Hildfield

917 E. Cumby St.

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C86622

CERTIFICATE OF DEATH

42 C86622
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 881 W. Franklin ST. 17 WARD)

FULL NAME Sarah S. Stanley

(Residence in Baltimore: No. 881 W. Franklin St. 50 yrs. - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widow

6-DATE OF BIRTH November 1 - (Month) (Day) (Year)

7-AGE 62 yrs. - mos. - ds. If LESS than 1 day, - hrs. or - min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Cambridge Md

10-NAME OF FATHER Wm. Sanders

11-BIRTHPLACE OF FATHER (State or country) Cambridge Md

12-MAIDEN NAME OF MOTHER Lillie A. Christopher

13-BIRTHPLACE OF MOTHER (State or country) Cambridge Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie L. Hush

(Address) 881 W. Franklin St.

15. JUL 12 1915. DEPT. OF HEALTH, BALTIMORE. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 11, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from June 16, 1915, to July 11, 1915.

that I saw her alive on July 10, 1915, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Uterus, Stomach, & Cervical Glands, Chr. Interstitial Nephritis (Duration) 3 yrs. - mos. - ds.

Contributory (SECONDARY) Exhaustion (Duration) yrs. - mos. - ds.

(Signed) S. Baldwin Jacobs, M. D. (Address) 841 N. Fremont Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. - mos. - ds. In the State yrs. - mos. - ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park July 13, 1915

20-UNDERTAKER

Geo. W. Little 531 N. Fremont Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *521 S. Hollington Ave* St.; *1* WARD)

2-FULL NAME

(Residence in Baltimore: No. *521 S. Hollington Ave* St.; *1* WARD)REGISTERED NO. C *79*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH

March 12th, 1837
(Month) (Day) (Year)

7-AGE

78 yrs. 4 mos. 1 ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer)

Caulker Ship

9-BIRTHPLACE, (State or Country)

Balt. City Md. Frederick Morlock

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUL 12 1915

CERT. EXAMINER

REG. NO. 101.5

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 12, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 30th* 191*5*, to *July 12th* 191*5*, that I saw him alive on *July 12th* 191*5*, and that death occurred, on the date stated above, at *10 P.* m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerotic degeneration

CONTRIBUTORY (Secondary)

(Signed)

A. T. R. M. D. *July 12th, 1915* (Address) *24 S. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *10 yrs. 4 mos. 1 ds.* In the State *10 yrs. 4 mos. 1 ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Mr. Samuel Campbell *July 14th, 1915*
J. Sander *1700 Beach St.*

Certificate of Death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word)

Single

6-DATE OF BIRTH,

Feb

26,

1915

(Month)

(Day)

(Year)

7-AGE,

yrs. 4 mos. 14 ds.

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE, (State or Country),

Baet

PARENTS.

10-NAME OF FATHER,

Carleton Bean

11-BIRTHPLACE OF FATHER (State or Country),

Baet

12-MAIDEN NAME OF MOTHER

Margaret Trotter

13-BIRTHPLACE OF MOTHER (State or Country),

Baet

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Mr. Margaret Bean

(Address).

3747 Morley St.

15-

JUL 12 1915

Filed..... 191

ROBERT KRAUTER

BALTIMORE PERMIT OFFICE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

12

1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from July 1, 1915, to July 12, 1915, that I saw him alive on July 11, 1915, and that death occurred, on the date stated above, at 5:30 A. M. The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Howard W. Jones, M. D.

July 12, 1915. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Baltimore

July 13, 1915

UNDERTAKER

ADDRESS

J. M. [illegible]

124 Mt. Royal ave

Caution: Do not destroy in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2145 Chelsea Ave St. 15 WARD)

FULL NAME

Baby Louis

(Residence in Baltimore: No. 2145 Chelsea Ave St. X yrs. X mos. 14 hrs.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

July
(Month)

11, 1915
(Day) (Year)

7-AGE

If LESS than
1 day, 14 hrs.
yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Home

9-BIRTHPLACE
(State or country)

Baltimore

PARENTS

10-NAME OF FATHER

Edwin A Louis

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Mary Virginia Thurston

13-BIRTHPLACE OF MOTHER
(State or country)

Mathews Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edwin A Louis

(Address)

#2145 Chelsea Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 12, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 11, 1915, to July 12, 1915,
that I saw her alive on July 11, 1915,
and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Blue Baby

Contributory
(SECONDARY)

(Signed)

Edwin A Louis M. D.
July 12, 1915 (Address) 1353 W. North Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Ritz Va

DATE OF BURIAL

July 13, 1915

20-UNDERTAKER

Charles E Fuller 221 N Broadway

15-

Filed

JUL 12 1915

REGISTRAR
J. KRAUTER
Social Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 Fleet St. ST.; 2 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1610 Fleet St.;

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 8 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Single
(Write the word.)6-DATE OF BIRTH Oct. 14, 1911
(Month) (Day) (Year)7-AGE 8 yrs. 29 mos. 29 ds. If LESS than 1 day, hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant9-BIRTHPLACE, (State or Country) Baltimore10-NAME OF FATHER Stanislaw Puszyrak11-BIRTHPLACE OF FATHER (State or Country) Russian Poland12-MAIDEN NAME OF MOTHER Madzyslaw Lyczkows13-BIRTHPLACE OF MOTHER (State or Country) Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanislaw Puszyrak(Address) 1610 Camden St. Baltimore15- JUL 12 1915 WILLIAM H. KRAUTERFiled 1915 WILLIAM H. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7/11/15, 191...
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 7/11/15 191... to 7/11/15 191...
that I saw her alive on 7/11/15 191...
and that death occurred, on the date stated above, at 9 45 m.
The CAUSE OF DEATH* was as follows:Acute Infectious Enteritis
(Duration) yrs. mos. 3 ds.CONTRIBUTORY (Secondary) Malnutrition(Signed) J. H. Harrison M. D.
7/11/15 191... (Address) 2919 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy RosaryDATE OF BURIAL, July 13, 191520-UNDERTAKER William FialkowskiADDRESS 1618 Eastern Ave

Cause of Death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C80627

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 East 22d.

ST. 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Hussey

(Residence in Baltimore: No. 19 East 22d.

St.; 52 yrs. mos. da)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 8, 1863

(Month)

(Day)

(Year)

7-AGE,

52 yrs. 0 mos. 3 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Martin Hussey

11-BIRTHPLACE OF FATHER

(State or Country)

Ireland

12-MAIDEN NAME OF MOTHER

Mary Plunkett

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Anna C. Hussey

(Address) 19 East 22d Street

15- JUL 12 1915

Filed.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 11, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 8, 1915, to July 11, 1915,

that I saw her alive on July 10, 1915,

and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary)

Acute Cholecystitis

(Duration) yrs. mos. 6 ds.

(Signed) Charles G. G. M. D.

July 12, 1915 (Address) 1111 N. Lombard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Mary's Cemetery, (G. over)

July 13, 1915

20-UNDERTAKER

ADDRESS

Henry W. Means & Son

505 N. Calver

CAUSE OF DEATH in plain text so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.;

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, 11 hrs.,

yrs.

mos.

ds.

or

min.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

JUL 12 1915
REGISTRAR

St Marys Hospital
Chenoweth & Co Chestnut Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

105 S. High

ST. 3 WARD)

FULL NAME

Hattie Cahlan

(Residence in Baltimore: No.

105 S High

St.: 18 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-~~SINGLE~~, MARRIED, WIDOWED OR DIVORCED (Write the word) Widows
6-DATE OF BIRTH unknown, 1 (Month) (Day) (Year)
7-AGE 64 yrs. — mos. — ds. or — min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Russia

10-NAME OF FATHER Solomon Cohen

11-BIRTHPLACE OF FATHER (State or country) Russia

12-MAIDEN NAME OF MOTHER Hattie Cohen

13-BIRTHPLACE OF MOTHER (State or country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel Cahlan

(Address) 105 S High st

15- JUL 12 1915 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH July 12, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May, 1915, to July 9, 1915, that I saw her alive on July 9, 1915, and that death occurred, on the date stated above, at 4 a. m. The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach
large tumor mass, metastasis
at visit on it (Clinical Diagnosis)
(Duration) 1 1/2 yrs. — mos. — ds.

Contributory (SECONDARY) Enterocolitis was (Duration) yrs. — mos. 14 ds.
(Signed) Frank R. Smith M. D.
July 15, 1915 (Address) 1126 Calver St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Super Roadside July 13, 1915

20-UNDERTAKER ADDRESS 1107 E

S. Ginn + Co Balto st

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86630

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86630

CERTIFICATE OF DEATH

28
REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2841 W North Ave. 15

WARD)

2-FULL NAME

Frances J. Spradden

(Residence in Baltimore: No. 2841 W North Ave. 15

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female white

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

May

22nd 1856

7-AGE

59

1

20

ds. or min.?

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Measurer

9-BIRTHPLACE

(State or country)

City

10-NAME OF FATHER

Hugh B. Spradden

11-BIRTHPLACE OF FATHER

Md.

12-MAIDEN NAME OF MOTHER

Mary J. Spradden

13-BIRTHPLACE OF MOTHER

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ella C. Spradden

(Address)

2841 W North Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July

12

1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 11, 1915, to July 12, 1915,

that I saw her alive on July 11, 1915,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonum
(Tuberculosis of lungs)

(Duration) 5 yrs. mos. ds.

Contributory
(SECONDARY)

Coronary atherosclerosis

(Duration) 3 yrs. mos. 12 ds.

(Signed),

Herbert E. Jeff

M. D.

July 12, 1915. [Address] 3050 N. Market

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mount Olivet

DATE OF BURIAL

July 14, 1915

20-UNDERTAKER

G. J. Walker

ADDRESS

723 W. Lf. Ave.

JUL 13 1915

HARRY O. ANDREWS,
BALTIMORE CITY CLERK

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Gough St.; 2 WARD)

REGISTERED NO. C

2-FULL NAME Emilia Katherine Belzner

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1816 Gough St.; yrs., 5 mos., 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, Jan. 28, 1915
(Month) (Day) (Year)7-AGE, 5 yrs., 17 mos., 17 ds.
If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Balto Md10-NAME OF FATHER, Louis J. Belzner11-BIRTHPLACE OF FATHER (State or Country), Balto Md12-MAIDEN NAME OF MOTHER Catherine Plarrant13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis J. Belzner(Address) 1816 Gough St.15- JUL 13 1915Filed 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 11, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from July 7 1915, to July 11 1915, that I saw her alive on July 11 1915, and that death occurred, on the date stated above, at 5:15 p.m.

The CAUSE OF DEATH* was as follows:

Gastric Intoxication
(Duration) ... yrs. ... mos. 5 ds.CONTRIBUTORY (Secondary) Constitutional(Duration) ... yrs. ... mos. 1 ds.(Signed) Geo. Heller M. D.7-12, 1915 (Address) 1937 Gough St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Immanuel Cemetery July 13, 1915

20-UNDERTAKER ADDRESS

Lilly & Ziehl 403 S. Wolfe

CAUSE OF DEATH is given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 Portugal ST. 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John M. Auffarth(Residence in Baltimore: No. 2004 Portugal St. 2 yrs. 9 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Oct 16, 1914
(Month) (Day) (Year)

7-AGE,

9 yrs. 26 mos. 26 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Child

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),Balto. Md.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),Balto. Md.

12-MAIDEN NAME OF MOTHER

Mamie Ginkand13-BIRTHPLACE OF MOTHER
(State or Country),Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John S. Auffarth(Address) 2004 Portugal St.

15-

FIND

JUL 13 1915

BARRY O. ANDREWS,

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 11, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 27 1915, to July 11 1915,that I saw him alive on July 11 1915,and that death occurred, on the date stated above, at 9:25 p.m.

The CAUSE OF DEATH* was as follows:

Enteric Intestitis(Duration) 14 yrs. 14 mos. 14 ds.CONTRIBUTORY
(Secondary)(Duration) 14 yrs. 14 mos. 14 ds.(Signed) Ed. Hoffman M. D.July 12 1915 (Address) 1937 George

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 14 yrs. 14 mos. 14 ds. In the State 14 yrs. 14 mos. 14 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn

DATE OF BURIAL,

July 15, 1915

20-UNDERTAKER

Lilly & Zeien

ADDRESS

405 S. Myrtle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86633

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86633

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1430 N Gay

ST. 8

WARD

2-FULL NAME

Henry Clantice

(if death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1430 N Gay

St. 79 yrs. 4 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widower

6-DATE OF BIRTH

March 4, 1896

(Month)

(Day)

(Year)

7-AGE

79

yrs.

4

mos.

7

ds.

or

min.?

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Produce Dealer
Hester

9-BIRTHPLACE

(State or country)

Baltimore md

10-NAME OF FATHER

John Clantice

11-BIRTHPLACE OF FATHER

Baltimore

12-MAIDEN NAME OF MOTHER

Rebecca Wilson

13-BIRTHPLACE OF MOTHER

Baltimore md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo Wassef

(Address)

1442 N Gay St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July

11

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 24, 1915, to July 11, 1915,

that I saw him alive on July 11, 1915,

and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis, Hypertrophied Prostate
Cystitis & Infinites

(Duration) yrs. mos. ds. (Don't know)

(Contributory (SECONDARY) Nephritis & Infinites (Duration) yrs. mos. ds. (Don't know)

(Signed) R.P. Carman M.D.

July 12, 1915 [Address] 1707 N Carolina

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green Mount Cemetery

July 14, 1915

20-UNDERTAKER

ADDRESS

Geo Wassef

1442 N Gay St

REGISTRAR

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *2332 Reisterstown Rd.* ST. *15* WARD)

2-FULL NAME

(Residence in Baltimore: No. *ditto* St.: yrs. mos. *0* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single
(Write the word)

6-DATE OF BIRTH

July 10, 1915
(Month) (Day) (Year)

7-AGE

10 yrs. *0* mos. *0* ds. or *2* hrs. *0* min. ?
If LESS than 1 day, 2 hrs. or min. ?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

Baltimore Md

10-NAME OF FATHER

Harriet H. Williams

11-BIRTHPLACE OF FATHER
(State or country)

Pennsylvania

12-MAIDEN NAME OF MOTHER

Cora May Clay

13-BIRTHPLACE OF MOTHER
(State or country)

Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. H. Williams

(Address)

2332 Reisterstown Rd

15-

JUL 13 1915

HARRY C. ANDREWS,
Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 10, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 10th, 1915 to *July 10, 1915*

that I saw him alive on *July 10, 1915*

and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

*premature birth
(6 mos. gestation)*

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *S. C. Dodels* M. D.

July 11, 1915 (Address) *3101 Clifton Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Peter's Cemetery

DATE OF BURIAL

July 13, 1915

20-UNDERTAKER

W. J. Tichner & Son

ADDRESS

Penn + Natl

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *601 Fair Oak Ave.* ST.; *9* WARD)

REGISTERED NO. C.

2-FULL NAME

Rachel Johns Keech

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *601 Fair Oak Ave.* St.; *—* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

Widow
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH

December 15th 1840
(Month) (Day) (Year)

7-AGE,

74 yrs., *6* mos., *27* ds.If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*none*
*none*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Dr. Johns*11-BIRTHPLACE OF FATHER
(State or Country),*not known*

12-MAIDEN NAME OF MOTHER

*not known*13-BIRTHPLACE OF MOTHER
(State or Country),*not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jas. K. Keech*(Address) *Towson, Md.*

15-

Filed

JUL 13 1915

191

ST. HARRY O. ANDERSON

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12th 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 7* 1915, to *July 12* 1915, that I saw her alive on *July 12* 1915, and that death occurred, on the date stated above, at *11:30 P.M.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) *3* yrs., *3* mos., *—* ds.

CONTRIBUTORY (Secondary)

Mitral Stenosis(Duration) *3* yrs., *3* mos., *—* ds.(Signed) *Hellie V. Marks* M. D.*July 13, 1915* (Address) *823 Hamilton Ave.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *—* yrs., *—* mos., *—* ds. In the State *—* yrs., *—* mos., *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Rock Spring Co., Harford Co., Md. *July 14th 1915*

20-UNDERTAKER

ADDRESS

Stewart Mowen Co *108 W. North W.*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1006 E Madison* ST.; *10* WARD)

REGISTERED NO. C

2-FULL NAME *Charles O. Butler*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1006 E Madison* St.; yrs., *7* mos. *8* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *male*4-COLOR OR RACE, *Caucasian*5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Dec 3rd, 1914*

(Month) (Day) (Year)

7-AGE, *7* yrs. *7* mos. *8* ds.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Jno Butler*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Margaret Bedford*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Margaret Bedford*(Address) *1006 E Madison St*

15-

Filed

JUL 13 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 11th, 1915*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 11, 1915* to *July 11, 1915*that I saw him alive on *July 11th, 1915*and that death occurred, on the date stated above, at *11* m.

The CAUSE OF DEATH* was as follows:

*Pneumonia**2 months* (Duration) yrs. *2* mos. *8* ds.CONTRIBUTORY, *Bronchitis*(Secondary) *14* yrs. *1* mo. *8* ds.(Signed) *Edward J. Fisher* M. D.*July 11, 1915* (Address) *1006 E Madison St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Laural Corn**July 13th, 1915*

20-UNDERTAKER

ADDRESS

Harry S. Voderberg 1725 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86637

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St. Joseph's Hospital - 3* REGISTERED NO. C.....
 CITY OF BALTIMORE (NO. *St. Joseph's Hospital - 3* ST. *3* WARD)
 FULL NAME *Angelina Gennetta -*
 Residence in Baltimore: No. *210 Summers ally* St.; - yrs., - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
 6-DATE OF BIRTH, *March 20, 1912*
 (Month) (Day) (Year)
 7-AGE, *3 yrs. 3 mos. 22 ds.* If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Philadelphia Pa*

10-NAME OF FATHER, *Salvatore Gennetta*
 11-BIRTHPLACE OF FATHER (State or Country), *Italy*
 12-MAIDEN NAME OF MOTHER *Raffaella Todio*
 13-BIRTHPLACE OF MOTHER (State or Country), *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Salvatore Gennetta*
 (Address) *210 Summers ally*

15 JUL 13 1915
 FILED..... 191.....

Registrar.

1 L. 110

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 12, 1915*
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *July 11, 1915* to *July 12, 1915*, that I saw her alive on *July 12, 1915*, and that death occurred, on the date stated above, at *40* m. The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria
 (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY..... *Broncho Pneumonia*
 (Secondary)

(Duration)..... yrs..... mos..... ds.
 (Signed) *Osceola V. Linhart* M. D.
 191... (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? *not known*

Former or usual residence *210 Summers ally*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *St. Vincent's Bene July 13, 1915*

20-UNDERTAKER, ADDRESS *Wendell D. P. & Son 378 East*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86638 HEALTH DEPARTMENT—CITY OF BALTIMORE

C86638

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CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 S Ann St ST.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 229 S Ann St St.; 2 yrs., 1 mos., 22 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH

May 20, 1853
(Month) (Day) (Year)

7-AGE

62 yrs., 1 mos., 22 da.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House Wife

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER

Steven Wabmayer

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Magdalen Skotarska(Address) 229 S Ann St

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 12, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July - 1 1915, to July 12 1915, that I saw h — alive on July 12 1915,

and that death occurred, on the date stated above, at 2 11 m.

The CAUSE OF DEATH* was as follows:

[Carcinoma] Liver
[Carcinoma] —
No operation —
(Duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary)

General Exhaustion
(Duration) yrs. 1 mos. da.(Signed) Frank B. Smith M. D.July 13, 1915. (Address) 125 S. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary

DATE OF BURIAL

July 14, 1915

20-UNDERTAKER

Winifred D. Apple

ADDRESS

37 S. M.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

JUL 13 1915

Filed

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BARRY O. ANDREWS,

Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86633

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

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C86633

PLACE OF DEATH

CITY OF BALTIMORE (No. 17 Lloyd

FULL NAME

Pearl Frybush (Frybush)

(Residence in Baltimore: No. 17 Lloyd St

ST. 3

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 23 mos. 14)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Unknown 1855 (Month) (Day) (Year)

7-AGE,

60 yrs. 1 mos. 1 da.

IF LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

work at home

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER (State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Frybush

(Address) 2327 McCullough St.

15-

JUL 13 1915

Filed

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12th, 1915 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Gastric Ulcer

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) M. D.

(Coroner.)

July 13, 1915 (Address) 3116 McCallum St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew B'nai B'rith July 13, 1915

20-UNDERTAKER

ADDRESS

S. Levinson & Co. Balto. Md.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

86640

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

119 86640

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

St.; - yrs. - mos. - da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

July 1, 1915, to July 11, 1915, that I saw her alive on July 11, 1915, and that death occurred, on the date stated above, at 7:15 p.m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. in the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

REGISTRAR

15-

Filed

JUL 13 1915.

191

REGISTRAR

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86641

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *319 Garrison Lane* ST. *20* WARD)2-FULL NAME *Carl Jungling*(Residence in Baltimore: No. *319 Garrison Lane* St. *20* yrs. *7* mos. *11* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*6-DATE OF BIRTH, *March 15, 1887*

(Month)

(Day)

(Year)

7-AGE, *34* yrs. *4* mos. *11* ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Baker*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Germany*

PARENTS.

10-NAME OF FATHER, *Carl Wilhelm Jungling*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Not known*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Emma Riske*(Address) *319 Garrison Lane*

15-

JUL 13 1915

FILED

191

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 11, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 13, 1915*, to *July 11, 1915*, that I saw him alive on *July 10, 1915*, and that death occurred, on the date stated above, at *8:45 p.m.*

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY (Secondary)

(Signed) *L. D. Wilson* M. D.*712 1/2, 191* (Address) *1733 Hillside*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Landon Park*DATE OF BURIAL, *July 13, 1915*20-UNDERTAKER *Harry A. Witzke*ADDRESS *1581 W. Lombard St.*

Cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 N. Linwood Ave ST.;

WARD)

2-FULL NAME

Mary E. Bruggmann

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 783 N. Linwood Ave St.;

yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) Married

6-DATE OF BIRTH,

June 1, 1895
(Month) (Day) (Year)

7-AGE,

20 yrs. 1 mos. 10 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...Housework9-BIRTHPLACE,
(State or Country),Md

10-NAME OF FATHER,

Mr. J. Phillips11-BIRTHPLACE OF FATHER
(State or Country),Md

12-MAIDEN NAME OF MOTHER

Caroline Gebhardt13-BIRTHPLACE OF MOTHER
(State or Country),Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Bruggmann(Address) 703 N. Linwood

15-

JUL 13 1915

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 11, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 11 1915, to July 11 1915,that I saw her alive on July 11 1915, and that death occurred, on the date stated above, at 5:25 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bright
Renal Disease
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)(Duration) yrs. mos. ds.
(Signed) A. D. Seaton M. D.
July 12, 1915 (Address) 2600 N. E. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Balto Cem.

DATE OF BURIAL,

July 14, 1915

20-UNDERTAKER

Philip Herwig

ADDRESS

2016 Orleans

Cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

C86643

HEALTH DEPARTMENT--CITY OF BALTIMORE.

C86643

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1208 Homewood ave. * 10 WARD)

3-FULL NAME

John Henry Michel

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1208 Homewood ave. * 60 yrs. 60 mos. 60 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)widowed

6-DATE OF BIRTH

June 30th

(Month)

(Day)

1836

(Year)

7-AGE

79

yrs.

mos.

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Retired Merchant General

9-BIRTHPLACE

(State or country)

German

10-NAME OF FATHER

John Michael11-BIRTHPLACE OF FATHER
(State or country)Germany

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or country)Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Anna R. Michel

(Address)

1208 Homewood ave.

15-

JUL 13 1915

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 12th

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1st, 1915, to July 12th, 1915,that I saw him alive on July 11th, 1915,and that death occurred, on the date stated above, at 7:45 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis,Contributory
(SECONDARY)Senile Heart with exhaustion,

(Signed)

William BrintonJuly 12th, 1915 [Address] Cabnet, America

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Balto CemeteryJuly 14 1915

20-UNDERTAKER

ADDRESS

Joseph Seyer 1800 W North Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *15*)FULL NAME *Helen Hook*(Residence in Baltimore: No. *1944 Walbrook Ave*)REGISTERED NO. C *47*WARD *15*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

St.; *—* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*4-COLOR OR RACE. *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)

6-DATE OF BIRTH.

Feb. (Month) *14* (Day), *1897* (Year)

7-AGE.

18 yrs., *5* mos., *—* ds. If LESS than 1 day, *—* hrs. or *—* min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housework*(b) General nature of industry, business, or establishment in which employed (or employer). *General*

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER, *Edw. Washington*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore Md.*12-MAIDEN NAME OF MOTHER *Lignes Lomera*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lignes L. Hook*(Address) *1944 Walbrook Ave*

15- JUL 13 1915

Filed *—* 191*5*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 12*, *1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 12* 191*5*, to *July 12* 191*5*, that I saw her alive on *July 12* 191*5* and that death occurred, on the date stated above, at *9:00 P.* m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Acute Articular Rheumatism(Duration) *3* yrs., *—* mos., *—* ds.CONTRIBUTORY (Secondary) *Acute Cardiac Dilatation*(Duration) *3* yrs., *—* mos., *—* ds.(Signed) *Edward P. Smith* M. D. (Address) *Mary Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs., *—* mos., *—* ds. In the State *16* yrs., *—* mos., *—* ds.Where was disease contracted, if not at place of death? *1944 Walbrook Ave*Former or usual residence *1944 Walbrook Ave*19-PLACE OF BURIAL OR REMOVAL, *St. Mary's Cemetery*DATE OF BURIAL, *July 14*, 191*5*20-UNDERTAKER *William Cook*ADDRESS *502 E. 1st St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86615

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86615

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1808 Hanover St

ST. 23 WARD)

REGISTERED No. C

2-FULL NAME Julia Hoofnagle

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1808 Hanover St

St. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

Female

White

6-DATE OF BIRTH,

May 12, 1877 (Month) (Day) (Year)

7-AGE,

38 yrs. 2 mos. ds.

IF LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

At Home

9-BIRTHPLACE,

(State or Country),

Balto Md

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hoofnagle

(Address) 1808 Hanover St

15-

JUL 13 1915

HARRY C. ANDREWS,

VITAL REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry find that said deceased came to Her death on the day stated above.

(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Abortion (Self inflicted)

(Duration) yrs. mos. ds.

CONTRIBUTORY Septicemia (Secondary)

(Duration) yrs. mos. 7 ds.

(Signed) M. D. (Coroner.)

517 Scott St (Address) July 12 1915

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill

July 14, 1915

20-UNDERTAKER

ADDRESS

Worlock

1026 North

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86646

C86646

CERTIFICATE OF DEATH.

28
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2621 Hudson* ST.; *1* WARD)

FULL NAME

Mary C. Chichowska
2631 Hudson(Residence in Baltimore: No. *2631 Hudson*)St.; *20* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Aug 1, 1873
(Month) (Day) (Year)

7-AGE,

41 yrs. 11 mos. 12 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Housewife*

9-BIRTHPLACE, (State or Country),

Austria

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

PARENTS.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary C. Chichowska*
(Address) *2631 Hudson*

15-

Filed

JUL 13 1915

GARRY O. ANDERSON

BARTOL BARNES GLOVE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Apr 25 1915* to *July 11 1915*, that I saw her alive on *July 11 1915* and that death occurred, on the date stated above, at *3:55 PM*.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs. mos. ds.(Signed) *Leo K. Karsinsky* M. D.*7/12/1915* (Address) *1116 S. Newwood*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Stanislaus *July 14, 1915*

20-UNDERTAKER

ADDRESS

Stephen F. Chalkowski *1012 S. Newwood*
and

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

JUL 13 1915.

Filed

191

HARRY G. ANDREWS,

TARIN Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

May 10 1915, to July 12 1915,

that I saw him alive on July 12 1915,

and that death occurred, on the date stated above, at 2:50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(Duration) 1 yrs. 6 mos. 1 da.

CONTRIBUTORY (Secondary) Ac. Pulmonary Edema

(Duration) 1 yrs. 1 day

(Signed) J. E. Earle, M. D.

July 12 1915 (Address) Md. General Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 2 mos. 2 da. In the 59 yrs. 9 mos. 9 da.

Where was disease contracted, if not at place of death? 1530 McCulloh St.

Former or usual residence 1530 McCulloh St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore

July 14, 1915.

20-UNDERTAKER

ADDRESS

Harris & Bradshaw

18 N. W. 17th

Cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

C86648

C86643

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1022 Wilcox St St.; - yrs., - mos., - ds.)

MEDICAL CERTIFICATE OF DEATH.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

Unknown Unknown, 1835
(Month) (Day) (Year)

**If LESS than 1 day,
....hrs. or....min.?**

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Maryland

Hickerson

Huberman

Heckman

Guthrie

(Informant) Barry's Records
(Address) St. Joseph Hospital

Filed JUL 13 1915

HARRY O. ANDREWS,

Serial Permit-Glor
Registrar.

16-DATE OF DEATH, July 13, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12 1915, to July 13 1915,
that I saw her alive on July 13 1915,
and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed) J. H. [Signature] M. N.
191... (Address) [Signature]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State Life yrs. ds.

Where was disease contracted, if not at place of death? 1024 Hylcon St

Former or usual residence 1022 Wilcox St.

10-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL, *July 13* 191*5*...

20-UNDERAKERV

20-UNDERTAKER
Chas. H. Jones

ADDRESS
1187.5th. Rayne

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2208 Eagle* ST.; *70* WARD)2-FULL NAME *Gordon J. S. Counselman*(Residence in Baltimore: No. *2208 Eagle* St.; yrs., *7* mos. *19* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

~~MARRIED~~~~WIDOWED~~~~OR DIVORCED~~

(Write the word.)

Single

6-DATE OF BIRTH

November 23, 1914
(Month) (Day) (Year)

7-AGE,

7 yrs., *19* mos., *19* da.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Infant*

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

PARENTS.

10-NAME OF FATHER,

Samuel Counselman

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Jennie Steitz

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Samuel Counselman

(Address)

2208 Eagle St.

15-

Filed

JUL 13 1915

191

DEPT. HEALTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 12* 1915, to *July 12* 1915, that I saw him alive on *July 12* 1915, and that death occurred, on the date stated above, at *11 A.* m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum
Stomach

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

Cardiac Weakness

(Duration) yrs. mos. da.

(Signed).....

A. S. Driscoll M. D.
July 12, 1915 (Address) *2205 Hickman Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL

JUL 14 1915

20-UNDERTAKER

Geo A Lerby

ADDRESS

Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

086650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

086650

PLACE OF DEATH

CITY OF BALTIMORE (No. 205 S Greene

ST. 22

WARD

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jerome Otter

(Residence in Baltimore: No. 705 S Greene

St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

July 1, 1915

(Month) (Day) (Year)

7-AGE,

12

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Balto Md

10-NAME OF FATHER,

John P Otter

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Bertha M Johnson

13-BIRTHPLACE OF MOTHER (State or Country),

Hagerstown Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John P Otter

(Address)

705 S Greene

15-

JUL 13 1915

JOHN P. KRAUTER,

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 1915

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature birth

(Eight months foetus)

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed)

July 13 1915

M. D.

(Coroner)

Address 217 S. Calverton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

In the

of death.... yrs. mos. da. State.... yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cemetery

DATE OF BURIAL,

July 13, 1915

20-UNDERTAKER

Jos Joverdus + Son

ADDRESS

217 S. Calverton Ave

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

86651

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

86651

PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

705 S Greene
John P. Otter
705 S Greene

ST.

WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Single

6-DATE OF BIRTH,

July 1, 1915
(Month) (Day) (Year)

7-AGE,

17 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE,

(State or Country),

Balto

10-NAME OF FATHER,

John P Otter

11-BIRTHPLACE OF FATHER

(State or Country),

Balto

12-MAIDEN NAME OF MOTHER

Bertha M Johnson

13-BIRTHPLACE OF MOTHER

(State or Country),

Hagerstown Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

John P Otter
705 S Greene

15-

JUL 13 1915

WALTER K. KROGER,

Filed

Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

premature birth
(Eight months fetus)
(Duration) yrs. mos. da.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. da.

(Signed) J. H. Deffen M. D.

July 13, 1915 (Address) 413 Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cemetery

DATE OF BURIAL,

July 13 1915

20-UNDERTAKER

Joe Jancho & Sons

ADDRESS,

217 S. Bea

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Adam Cicierski
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 308 S. Bond ST. 3 WARD)

2-FULL NAME Adam Cicierski

(Residence in Baltimore: No. 308 S. Bond

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RR out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH Dec 29 1914 (Month) (Day) (Year)

7-AGE 6 yrs. 16 mos. 16 ds. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Balto.

PARENTS

10-NAME OF FATHER Ludwik Cicierski

11-BIRTHPLACE OF FATHER (State or country) Russia

12-MAIDEN NAME OF MOTHER Julia Bucynska

13-BIRTHPLACE OF MOTHER (State or country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ludwik Cicierski

(Address) 308 S. Bond St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 13 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 10, 1915, to July 13, 1915, that I saw him alive on July 13, 1915, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Contributory (SECONDARY)

(Signed) Nathan J. Helfgott July 13, 1915 [Address] 204 S. Bond

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Rosary

July 14, 1915

REGISTRAR

ADDRESS

Jacob Frankowski 428 S. Bond

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1736 Lancaster*

2-FULL NAME

(Residence in Baltimore: No. *1736 Lancaster*ST. *2*

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. *9* mos. *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

*Oct**1**1914*

(Month)

(Day)

(Year)

7-AGE,

yrs. *9*mos. *12*

ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

John Brink

11-BIRTHPLACE OF FATHER

(State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Agnes Jergatz

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Agnes Brink*(Address) *1736 Lancaster St.*

15- JUL 13 1915

Filed..... 191

STENT

KRAUTER,

Sup. 1st. Mort.

Regist.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**13**1915*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

July 10

1915, to

July 13

1915,

that I saw him alive on

July 13

1915,

and that death occurred, on the date stated above, at *11* m.

The CAUSE OF DEATH* was as follows:

acute pneumonia

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY

(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *J. J. Maloney*

M. D.

1915 (Address) *65 Bond*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

July 14

1915

20-UNDERTAKER

M. J. Sadowski

ADDRESS

705 S. E. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hosp 21*) WARD) REGISTERED NO. C
2-FULL NAME *Andrew Reese*
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *1131 S. Sharpe St.* St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
6-DATE OF BIRTH, *Jan 25*, 1915. (Month) (Day) (Year)
7-AGE, *6* yrs. *17* mos. *17* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

md.

PARENTS.

10-NAME OF FATHER,

Andrew Reese

11-BIRTHPLACE OF FATHER (State or Country),

md.

12-MAIDEN NAME OF MOTHER

Louise Lettan

13-BIRTHPLACE OF MOTHER (State or Country),

md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Phelps*(Address) *Johns Hopkins Hosp.*

15-

Filed

*JUL 13 1915**JOHN HOPKINS HOSP.**HOSPITAL PERMIT CLERK*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 13, 1915. (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *July 3*, 1915, to *July 13*, 1915, that I saw him alive on *July 13*, 1915, and that death occurred, on the date stated above, at *2* a.m.

The CAUSE OF DEATH was as follows:

acute intestinal indigestion

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *A. A. Batten**July 13*, 1915. (Address) *Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the *6* State *17* mos. ds.Where was disease contracted, if not at place of death? ☒Former or usual residence *1131 S. Sharpe St.*

19-PLACE OF BURIAL OR REMOVAL

Linden Park Cemetery

DATE OF BURIAL

July 15, 1915.

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 N. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1115 N. Hamburg* ST.: *21* WARD)2-FULL NAME *Olinor E. Titlow*(Residence in Baltimore: No. *1115 N. Hamburg* St.: *76* yrs., *7* mos., *22* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*6-DATE OF BIRTH, *Nov 20th*, *1838*

(Month)

(Day)

(Year)

7-AGE, *76* yrs., *7* mos., *22* ds.

IF LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *House*(b) General nature of industry, business, or establishment in which employed (or employer) *House*9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *John Titlow*11-BIRTHPLACE OF FATHER (State or Country), *U. S.*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Hellmuth M.D.*(Address), *1000 W. Cross St.*

15-

JUL 13 1915

Filed..... 191.....

DEPT. . ERAUTER

CAPITAL PERMIT

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 12th*, *1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 6th* 1915, to *July 12th* 1915,that I saw him alive on *July 12th* 1915,and that death occurred, on the date stated above, at *4 P. m.*

The CAUSE OF DEATH* was as follows:

Heart prostration
& old age

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) *Heart failure*

(Duration)..... yrs..... mos..... ds.

(Signed), *Hellmuth* M. D.*July 12th*, 1915. (Address) *1000 W. Cross St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Western Cemetery*DATE OF BURIAL, *July 14th*, 191520-UNDERTAKER *Joe B. Cook*ADDRESS *1003 N. Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2114 E Fairmount* ST.; *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2114 E Fairmount* are St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE.

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Pauline C. Crumling*(Address) *2114 E Fairmount*

15-

Filed

JUL 13 1915

101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17 I HEREBY CERTIFY, That I attended deceased from

May 21 1915, to *July 12* 1915,that I saw him alive on *July 11* 1915,and that death occurred, on the date stated above, at *1:10* a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Adolph C. Eisenberg* M. D.*July 13*, 1915. (Address) *2721-3 Orleans St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Libby Reisterman Ave**July 15*, 1915.

20-UNDERTAKER

ADDRESS,

*Winchell Shyfel & Son**2721-3 Orleans St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 Fairmount ST. 6 WARD)

2-FULL NAME

Lawrence Heinel

Residence in Baltimore: No.

2001 Fairmount

St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Infant

6-DATE OF BIRTH,

Feb26, 1915

(Month)

(Day)

(Year)

7-AGE,

17 yrs. 17 mos. 17 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE,

(State or Country),

Balt

10-NAME OF FATHER,

Jacob Heinel

11-BIRTHPLACE OF FATHER

(State or Country),

Balt

12-MAIDEN NAME OF MOTHER

Catherine Fritch

13-BIRTHPLACE OF MOTHER

(State or Country),

Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Heinel(Address) 2001 Fairmount

15- JUL 13 1915. ROBERT BRAUTER, Registrar.

Filed..... 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July13, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 12 1915, to July 13 - 1915,that I saw h — alive on July 12 1915,and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Convulsions8 hours (Duration)

yrs. mos. ds.

CONTRIBUTORY (Secondary)

Simple (Duration) yrs. mos. ds.(Signed) Robert Brauter M. D.July 13, 1915. (Address) 125 E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer ChJuly 14 1915

20-UNDERTAKER

ADDRESS

Wendell Shippey 57 S. Am St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86658

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86658

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1826 N. Dallas* ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1826 N. Dallas St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

July 13, 1915
(Month) (Day) (Year)

7-AGE.

If LESS than 1 day.

yrs. mos. da. hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country),*Baltimore M. d.*

PARENTS.

10-NAME OF FATHER,

*Henry Holtzmann*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore M. d.*

12-MAIDEN NAME OF MOTHER

*Christine Parr*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore M. d.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Holtzmann*(Address) *1826 N. Dallas St.*

15-

JUL 14 1915

HARRY O. ANDREWS,

Filed 1915

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 13, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *July 13* 1915, to *July 13* 1915, that I saw her alive on *July 13* 1915, and that death occurred, on the date stated above, at *2:35 P.* m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(Duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) *Elmer C. Hall* M. D.*July 13*, 1915. (Address) *1617 E. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Redeemer

DATE OF BURIAL.

July 14, 1915

20-UNDERTAKER

Henry Hoeck & Son 1301 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86659

C86659

CERTIFICATE OF DEATH.

x 137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Hospital*)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *Petersburg Va*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female White

4-COLOR OR RACE.

5-STATUS.
MARRIED, *married*
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Unknown, 1

(Month)

(Day)

(Year)

7-AGE,

34 — yrs. — mos. — ds.

If LESS than 1 day.

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Housework at home*

9-BIRTHPLACE

(State or Country)

Russia

10-NAME OF FATHER,

Abraham Miller

11-BIRTHPLACE OF FATHER

(State or Country).

Russia

12-MAIDEN NAME OF MOTHER

Mary Glick

13-BIRTHPLACE OF MOTHER

(State or Country).

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Louis Bank
Petersburg Va

(Address)

15-

Filed

JUL 14 1915

HARRY O. ANDREWS,

Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 13, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 25 1915, to *July 13 1915*,that I saw her alive on *July 13 1915*,and that death occurred, on the date stated above, at *11 A.* m.

The CAUSE OF DEATH* was as follows:

Puerperal Infection

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY

(Secondary)

Infection (Duration) ... yrs. ... mos. ... ds.(Signed) *M. A. Weinberg* M. D.*July 13, 1915* (Address) *1804 Madison Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds. State ...

Where was disease contracted, if not at place of death? *Petersburg Va*Former or usual residence *Petersburg Va*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Shaw Blair Rd**July 13 1915*

20-UNDERTAKER

ADDRESS *1107 E**J. Linnson & Co* *Balto*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *1028 W. Lexington* St. *18* WARD)
FULL NAME *Helen Moulder*
(Residence in Baltimore: No. *1028 W. Lexington* St. *1* yrs., *1* mos. *14* ds.)
(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*
4-COLOR OR RACE, *Colored*
5-SINGLE, *Single*
6-DATE OF BIRTH, *May 28th, 1914*
7-AGE, *1* yrs., *1* mos., *14* ds.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), *Balto. Md*
10-NAME OF FATHER, *John Moulder*
11-BIRTHPLACE OF FATHER, (State or Country), *Md*
12-MAIDEN NAME OF MOTHER, *Mary Taskel*
13-BIRTHPLACE OF MOTHER, (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Moulder*
(Address) *1028 W. Lexington St.*

15-*JUL 14 1915*
Filed *1915* *HARRY O. ANDREWS,*
Marial Permit. Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 12th, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry*
(Inquest, autopsy or inquiry.)

And that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cholera Infantum
(Duration) *3* yrs. *3* mos. *3* ds.

CONTRIBUTORY (Secondary)

(Signed) *Sam'l Thompson* M. D.
(Coroner) *July 13th 1915* (Address) *2302 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death *1* yrs. *1* mos. *14* ds. State *1* yrs. *1* mos. *14* ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Mt. Auburn Cem* DATE OF BURIAL, *July 14, 1915*

20-UNDERTAKER, *Wm. J. Ireland* ADDRESS, *114 N. Schreder St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *22 E. 25th* ST.; *12* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Susan Stevenson Maynard*(Residence in Baltimore: No. *22 E. 25th* St. *Life* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*6-DATE OF BIRTH, *July 6th 1834* (Month) (Day) (Year)7-AGE, *81* yrs. *7* mos. *7* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Baltimore Md*10-NAME OF FATHER, *Joshua Stevenson*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Helena Kaff*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annina Maynard*(Address) *22 E. 25th St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 13, 1915* (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *July 4th 1915*, to *July 13th 1915*, that I saw her alive on *July 13 1915*, and that death occurred, on the date stated above, at *9 P* m. The CAUSE OF DEATH* was as follows:*Cerebral hemorrhage (right hemisphere)* (Duration).....yrs.....mos.....ds. *7*

CONTRIBUTORY (Secondary)

(Signed) *W. B. Stephens* M. D. *July 13, 1915*. (Address) *1008 Cathedral*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Prospect Hill C.E. Cem.* DATE OF BURIAL, *7-15, 1915*20-UNDERTAKER *Henry W. Jenkins & Son Co* ADDRESS *Orchard*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

18-
Filed *JUL 14 1915* HARRY O. ANDREWS, Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *947 W Lombard* ST.; *18* WARD)

REGISTERED NO. C

3-FULL NAME

Residence in Baltimore: No. *947 W Lombard* St.; *6* yrs., *10* mos., *17* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Aug 26, 1908
(Month) (Day) (Year)

7-AGE,

6 yrs., *10* mos., *17* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*W. Thomas Stewart*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore*

12-MAIDEN NAME OF MOTHER

*Fredericka Burzgraf*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *W. T. Stewart*(Address) *947 W Lombard*

15-

Filed

*JUL 14 1915**HARRY O. ANDREWS,*

Serial Permit Office

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 11, 1915*, to *July 13, 1915*, that I saw him alive on *July 12, 1915*, and that death occurred, on the date stated above, at *830 A* m.

The CAUSE OF DEATH* was as follows:

Enteritis(Duration) *7* yrs., *14* mos., *14* ds.CONTRIBUTORY
(Secondary)(Duration) *2* yrs., *2* mos., *2* ds.(Signed) *Edmund Stewart* M. D.*July 14, 1915* (Address) *517 W. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *6* yrs., *10* mos., *17* ds. In the State *6* yrs., *10* mos., *17* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Cemetery *July 15, 1915*

20-UNDERTAKER

ADDRESS

F. B. Steppert 2238 Frederick Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86663

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86663

CERTIFICATE OF DEATH.

137
REGISTERED No. C.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hop* ST.; *10* WARD)
2-FULL NAME *Shannie Nixon*
(Residence in Baltimore: No. *908 Donnelly St* St.; — yrs., — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*
4-COLOR OR RACE, *Black*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
6-DATE OF BIRTH, *Unknown*, 1.....
(Month) (Day) (Year)
7-AGE, *39* yrs. mos. ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer) *Domestic*
9-BIRTHPLACE, (State or Country), *md.*

PARENTS.
10-NAME OF FATHER, *Don't know*
11-BIRTHPLACE OF FATHER (State or Country), *md.*
12-MAIDEN NAME OF MOTHER *Don't know*
13-BIRTHPLACE OF MOTHER (State or Country), *md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Phelps*
(Address) *Johns Hopkins Hop*

15-
JUL 14 1915
Filed....., 191..
HARRY O. ANDREWS
Merial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July* 12, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *July 6* 1915, to *July 12* 1915, that I saw her alive on *July 12* 1915, and that death occurred, on the date stated above, at *11:30* a.m.

The CAUSE OF DEATH* was as follows:

General Peritonitis
(Pneumonia)
(Duration) *5* yrs. mos. ds.
CONTRIBUTORY *labors*
(Secondary) (Duration) *5* yrs. mos. ds.

(Signed) *C. P. Phelps* M. D.
July 12, 1915. (Address) *Johns Hopkins Hop*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *6* yrs. mos. ds. In the *39* yrs. mos. ds.

Where was disease contracted, *908 Donnelly St*
if not at place of death?

Former or usual residence *908 Donnelly St*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Laurel Cem**July 14, 1915*

20-UNDERTAKER

ADDRESS *306d**Willard Brown**Mont St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Provident Hospital* ST. *5* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *508 N. Eden* St.: — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Unknown, 1.....
(Month) (Day) (Year)

7-AGE,

44 yrs., — mos., — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Domestic

9-BIRTHPLACE, (State or Country),

MD

PARENTS.

10-NAME OF FATHER,

Don't Know

11-BIRTHPLACE OF FATHER (State or Country),

MD

12-MAIDEN NAME OF MOTHER

Don't Know

13-BIRTHPLACE OF MOTHER (State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Engene Halton*(Address) *508 N. Eden St.*

15-

JUL 14 1915

HARRY C. ANDERSON,

191... Marial Permit. Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 191*5*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 22, 191*5*, to *July 12*, 191*5*.that I saw her alive on *July 12*, 191*5*.and that death occurred, on the date stated above, at *8:45* pm.

The CAUSE OF DEATH* was as follows:

Spasms - intestinal Catarrh

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

Acute Nephritis

(Duration)..... yrs..... mos..... ds.

(Signed).....

J. C. Robinson M. D.*July 12*, 191*5*. (Address) *611 N. E. 4th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the *44* yrs..... mos..... ds. State *MD*Where was disease contracted, if not at place of death? *508 N. Eden St.*Former or usual residence *508 N. Eden*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Trigate Point MD *July 15*, 191*5*.

20-UNDERTAKER

ADDRESS

W. A. Elliott *506 East St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86665		HEALTH DEPARTMENT—CITY OF BALTIMORE		151 C86665	
PLACE OF DEATH		CERTIFICATE OF DEATH		REGISTERED No. C	
CITY OF BALTIMORE (No. <i>245 - Dolphin</i>)		ST. <i>11</i> WARD)		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
FULL NAME <i>William Reiko</i>		St. yrs. mos. <i>7 2 6</i>			
(Residence in Baltimore: No. <i>245 - Dolphin</i>)					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Single</i> (Write the word)			
6 DATE OF BIRTH <i>July 12, 1915</i> (Month) (Day) (Year)					
7 AGE <i>7 yrs. 2 mos. 6 ds.</i> If LESS than 1 day, 12 hrs. or less, 7					
8 OCCUPATION <i>None</i> (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE <i>Baltimore</i> (State or country)					
PARENTS	10 NAME OF FATHER <i>Harry Reiko</i>				
	11 BIRTHPLACE OF FATHER <i>Baltimore</i> (State or country)				
	12 MAIDEN NAME OF MOTHER <i>Cashin Reiko</i>				
	13 BIRTHPLACE OF MOTHER <i>Baltimore</i> (State or country)				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>W S Love</i> (Address) <i>836 W. N. Ave.</i>					
15 JUL 14 1915. HARRY C. ANDERSON, Registrar Filed, 1915. Burial Permit Oler's					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <i>July 12, 1915</i> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <i>July 12, 1915</i> to <i>July 12, 1915</i> that I saw him alive on <i>July 12, 1915</i> and that death occurred, on the date stated above, at <i>3:30</i> pm. The CAUSE OF DEATH* was as follows: <i>Was only 5 mos. development - (pregnancy)</i>					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <i>College of P. & S.</i> DATE OF BURIAL <i>JUL 14 1915</i>					
20 UNDERTAKER <i>Commissioner Health.</i> ADDRESS					

FOR ANATOMICAL PURPOSES

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *128 Jackson Place*)

ST. *6*

WARD

2-FULL NAME

Max Berger

(Residence in Baltimore: No. *128 Jackson Place*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *2* yrs., *7* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Child*

6-DATE OF BIRTH.

Mei

13

1913

(Month)

(Day)

(Year)

7-AGE.

2

4

1

ds.

If LESS than 1 day.

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9-BIRTHPLACE. (State or Country).

Balto City Md

10-NAME OF FATHER.

Jacob Berger

11-BIRTHPLACE OF FATHER (State or Country).

Russia

12-MAIDEN NAME OF MOTHER

Ella Snyder

13-BIRTHPLACE OF MOTHER (State or Country).

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Lewis*

(Address) *419 E. Balto St*

15-

JUL 14 1915

HARRY O. ANDREWS,

Filed

191

Marital Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July

14

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sarcoma of Head (Osteosarcoma)

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Elyan J. Russell* M. D.
(Coroner.)

July 14, 1915 Address *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Hebrew Rose Dale

July 15, 1915

20-UNDERTAKER

ADDRESS

Jack Lewis

1419 E. Balto St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86667

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 S. Linwood ave. WARD)

2-FULL NAME

(Residence in Baltimore: No. 135 S. Linwood an St.; 1 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH,

Sept 16, 1913
(Month) (Day) (Year)

7-AGE,

1 yrs., 9 mos., 26 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION,

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Ind

10-NAME OF FATHER,

Raymond R. Sprague

11-BIRTHPLACE OF FATHER (State or Country),

Ill.

12-MAIDEN NAME OF MOTHER

Margaret McLean

13-BIRTHPLACE OF MOTHER (State or Country),

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Sprague(Address) 135 S. Linwood an

15-

Filed JUL 14 1915 HARRY O. ANDREWS
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from July 1, 1915, to July 12, 1915, that I saw her alive on July 11, 1915, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(Duration).....yrs.....mos. 1 ds.CONTRIBUTORY...Toxemia(Duration).....yrs.....mos. 3 ds.(Signed) M. J. Mcawoy M. D.July 13, 1915 (Address) 839 S. Ellwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Hos. Green July 14, 1915

20-UNDERTAKER

ADDRESS

John A. Moran Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86668

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86668

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Winans Cove ST. 12 WARD)
2-FULL NAME Wesley V Linthicum
(Residence in Baltimore: No. 2608 Calvert St)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

By 18 yrs., 11 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single
6-DATE OF BIRTH, July 30, 1896
(Month) (Day) (Year)
7-AGE, 18 yrs., 11 mos., 13 ds. If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

Baltimore Md

PARENTS.

10-NAME OF FATHER, Herbert R Linthicum

11-BIRTHPLACE OF FATHER
(State or Country),

Balto Md

12-MAIDEN NAME OF MOTHER Cora Rothbecker

13-BIRTHPLACE OF MOTHER
(State or Country),

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... J. Charles Linthicum

(Address)..... St. Paul St.

15-

JUL 14 1915

HARRY O. ANDERSON

Filed..... 191... Burial Permit 0107
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-

Inquiry..... and that said deceased came to His death
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

July 12, 1915 (Address)..... 517 Scott St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Woodrow Park Cemetery July 15, 1915

20-UNDERTAKER ADDRESS,

George J. Smith 1000 E. 7th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86669

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

March 29, 1903

7-AGE,

12 yrs. 3 mos. 19 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

School-girl

9-BIRTHPLACE, (State or Country),

Montana

10-NAME OF FATHER,

John W. Barnett

11-BIRTHPLACE OF FATHER (State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Pearl Bryant

13-BIRTHPLACE OF MOTHER (State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed JUL 14 1915

HARRY C. ANDREWS,

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from July 3, 1915 to July 12, 1915, that I saw him alive on July 12, 1915,

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute mitral & tricuspid endocarditis - rheumatic

(Duration)..... yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

Myocardial infarction. Pulmonary infarction. Pneumonia (Duration)..... yrs. mos. 12 ds.

(Signed)..... M. D.

July 12, 1915. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. 9 ds. In the State..... yrs. mos. 9 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Independence, Va.

19-PLACE OF BURIAL OR REMOVAL,

Independence, Va.

DATE OF BURIAL,

July 14, 1915.

20-UNDERTAKER

Arthur C. Fuller

ADDRESS

221 N. Broadway

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

C86670

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86670

CERTIFICATE OF DEATH

79

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. *1029* *Green Alley* *18* ST. WARD)

2-FULL NAME *Mary Pratt*

Residence in Baltimore: No. *1029 Green's Alley* St. *13* yrs. *13* mos. *13* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Caucasian* 5-SINGLE *Widow*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Unknown*
(Month) (Day) (Year)

7-AGE *13* yrs. *13* mos. *13* ds. If LESS than 1 day, hrs., min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *Domestic*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore Md.*

10-NAME OF FATHER *Charles Thompson*

11-BIRTHPLACE OF FATHER (State or country) *Balto Md.*

12-MAIDEN NAME OF MOTHER *Ella Chisholm*

13-BIRTHPLACE OF MOTHER (State or country) *Balto Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Martha Jough*

(Address) *1111 Rabun St*

JUL 14 1915

HARRY O. ANDREWS,

Filed

191

Marital Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *July 12, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 29, 1915*, to *July 12, 1915*, that I saw him alive on *July 11, 1915*, and that death occurred, on the date stated above, at *10 P* m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Contributory (SECONDARY) *Pulmonary Arteriosclerosis*
(Duration) yrs. mos. ds.

(Signed) *J. H. Norwood* M. D.
July 13, 1915 [Address] *937 N. Taylor St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Millbrook Cem. *July 14, 1915*

20-UNDERTAKER

ADDRESS

John H. Hagan *901 Hollins St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hosp* ST.; *11* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1213 Park Ave* St.; *104* yrs., *11* mos., *11* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Black*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*single*

6-DATE OF BIRTH

Sept. 13, 1913

(Month)

(Day)

(Year)

7-AGE,

1 yrs. 10 mos. 11 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Ind.*

10-NAME OF FATHER,

*Charles Nickens*11-BIRTHPLACE OF FATHER
(State or Country),*Pa.*

12-MAIDEN NAME OF MOTHER

*Guy Hill*13-BIRTHPLACE OF MOTHER
(State or Country),*Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. Neudecker*(Address) *John Hopkins Hosp.*

15-JUL 14 1915

JOSEPH KRAUTER,

Filed....., 191.....

Medical Permit No. *104*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 10* 191*5*, to *July 14* 191*5*, that I saw him alive on *July 14* 191*5*, and that death occurred, on the date stated above, at *3:50* A.M. The CAUSE OF DEATH* was as follows:*Acute Intestinal Indigestion*(Duration).....yrs.....mos. *4*.....ds.CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *G. A. Ballou*

M. D.

July 14, 1915 (Address) *John Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. *4*.....ds. In the State.....yrs.....mos.....ds.Where was disease contracted, if not at place of death? *✓*

Former or usual residence

1213 Park Avenue

19-PLACE OF BURIAL OR REMOVAL,

Laurel

DATE OF BURIAL,

July 16, 1915

20-UNDERTAKER

R. J. Howell

ADDRESS

*12080 Mt. Ave.**Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86672
1 PLACE OF DEATH

170
C86672
REGISTERED No. C

CITY OF BALTIMORE: (No. 1032 N. Payson St. ST. 16 WARD)

2-FULL NAME Henry Newman

(Residence in Baltimore: No. 1032 N. Payson St.; 25 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE white 5-SINGLE Married MARRIED WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH July 24 1845 (Month) (Day) (Year)

7-AGE 69 yrs. 11 mos. 19 ds. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work Retired Soldier (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Germany

PARENTS 10-NAME OF FATHER Unknown 11-BIRTHPLACE OF FATHER (State or country) Unknown 12-MAIDEN NAME OF MOTHER Unknown 13-BIRTHPLACE OF MOTHER (State or country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Flora Zitzer (Address) 1032 N. Payson

15- JUL 14 1915 DEERT . KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 13 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 11, 1915, to, July 13, 1915, that I saw him alive on July 12, 1915, and that death occurred, on the date stated above, at 9³⁰ a.m. The CAUSE OF DEATH* was as follows:

Chron. Nephritis
unknown (Duration) yrs. mos. ds.
Contributory (SECONDARY) uraemia — yrs. mos. 10 ds.
(Signed) Chas. C. Conser M.D.
7-13 1915 [Address] 110 N. Fulton Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death... yrs. mos. ds. State... yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL National Cem DATE OF BURIAL July 15 1915
20-UNDERTAKER Harry W. Cohen ADDRESS 1944
W. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2634 Frederick Ave* ST. *20* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2634 Frederick Ave* St. *Lifetime* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH

Dec 29th, 1878
(Month) (Day) (Year)

7-AGE

36 yrs. *6* mos. *15* da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Grocery Store
Prepper

9-BIRTHPLACE, (State or Country)

Baltimore Md.

10-NAME OF FATHER

August Hoffmeister

11-BIRTHPLACE OF FATHER (State or Country)

Germany

12-MAIDEN NAME OF MOTHER

Mary Brandau

13-BIRTHPLACE OF MOTHER (State or Country)

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lena Hoffmeister*(Address) *2634 Frederick Ave*

15-

JUL 14 1915

ROBERT KRAUTER

Filed

191

Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 13th, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *May 27* 1915, to *July 12* 1915, that I saw him alive on *July 12* 1915, and that death occurred, on the date stated above, at *4:30* A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) yrs. *2* mos. *4* ds.

CONTRIBUTORY (Secondary)

Septic Infection of Throat(Duration) yrs. mos. *10* ds.

(Signed)

J. H. Brown M. D.*July 13, 1915* (Address) *1328 1/2 Charles St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Western Cemetery

DATE OF BURIAL

July 14th, 1915

20-UNDERTAKER

Mrs. John H. Seufel

ADDRESS

801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1315 S. Homewood Ave* ST. *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1315 S. Homewood Ave* St.;

yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widowed

6-DATE OF BIRTH,

Mar 20, 1855

(Month)

(Day)

(Year)

7-AGE,

60 yrs. *3* mos. *23* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER,

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER,

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

Filed

JUL 14 1915

ROBERT J. KRAUTER,

Notary Public

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY That I attended deceased from

July 1, 1915, to *July 12*, 1915,that I saw her alive on *July 12*, 1915,and that death occurred, on the date stated above, at *9 P. m.*

The CAUSE OF DEATH* was as follows:

Diat. etc. Mellitus(Duration) yrs. *6* mos. *12* ds.

CONTRIBUTORY (Secondary)

Coma(Signed) *J. H. Robinson* M. D.*July 14*, 1915. (Address) *726 E. Pratt St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Mary's Home, *July 14*, 1915.

20-UNDERTAKER

ADDRESS

H. C. Bridgford, *1315 S. Homewood Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86675

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

320 S. Paca

ST.;

WARD)

REGISTERED NO. C

2-FULL NAME

George D. Wernex

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

320 S. Paca

St.; 71 yrs., 1 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 4, 1844
(Month) (Day) (Year)

7-AGE,

71 yrs., 1 mos., 9 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Cigar Store

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

Harman H. Wernex

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Catherine A. Wernex

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Lizzie Wernex(Address) 320 S. Paca

15-

JUL 14 1915

Filed..... 191.....

J. KRAUTER

Bureau Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 13, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 13, 1915, to July 13, 1915, that I saw him alive on July 13, 1915, and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. 4 mos. do.

CONTRIBUTORY
(Secondary)

Uremia

(Duration) yrs. mos. do.

(Signed) Jos. H. Lempert, M. D.July 13, 1915. (Address) 645 Columbia

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or VICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. do. In the State yrs. mos. do.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore City

July 13, 1915

20-UNDERTAKER

ADDRESS

Jos. J. J. J. J.

217 S. Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *6* WARD)2-FULL NAME *Raymond Sheppard*(Residence in Baltimore: No. *1704 Orleans St.* St. *6* yrs. *14* mos. *14* ds.)REGISTERED NO. C *86676*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)

6-DATE OF BIRTH,

January 28, 1915
(Month) (Day) (Year)

7-AGE,

5 1/2 yrs. *2* mos. *14* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None.*9-BIRTHPLACE,
(State or Country),*md.*

10-NAME OF FATHER,

*John Green*11-BIRTHPLACE OF FATHER
(State or Country),*md.*

12-MAIDEN NAME OF MOTHER

*Margaret Sheppard*13-BIRTHPLACE OF MOTHER
(State or Country),*md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. P. Shell*(Address) *Johns Hopkins Hospital*

15-

Filed *JUL 14 1915**ROBERT KRAUTER**Special Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 13, 1915, to July 14, 1915
that I saw him alive on *July 14, 1915*,
and that death occurred, on the date stated above, at *179* a.m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion(Duration) *5 1/2* yrs. *5* mos. *14* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. *1* mos. *14* ds.(Signed) *G. A. Batten**July 14, 1915* (Address) *Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *14* ds. In the State *1* yrs. *1* mos. *14* ds.Where was disease contracted, if not at place of death? *✓*Former or usual residence *1704 Orleans St.*

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

July 16, 1915

20-UNDERTAKER

Chas. E. Bailey

ADDRESS

1421 Jefferson St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

13. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

86677 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 701 Refuge court, St. 15 WARD)

FULL NAME Winifred A. Fahey,

(Residence in Baltimore: No. 701 Refuge court,

79 86677
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, Unknown, / (Month) (Day) (Year)

7-AGE, 28 yrs. ? mos. ? ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Domestic, (b) General nature of industry, business, or establishment in which employed (or employer), in restaurant.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Michael T. Fahey,

11-BIRTHPLACE OF FATHER (State or Country), Maryland,

12-MAIDEN NAME OF MOTHER Agnes E. Kelly,

13-BIRTHPLACE OF MOTHER (State or Country), Ireland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes E. Cochran, mother,

(Address) 1315 Woodyear street.

15 JUL 14 1915

Filed..... 191.....

Serial Permit 018

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 13th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. (Inquest, au-

topsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Organic heart disease. (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) (Duration).....yrs.....mos.....ds.

(Signed) J. Frederick M. D. (Coroner.)

July 13 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Peters July 15, 1915

20-UNDERTAKER ADDRESS

M. Fahey & Sons 606 Lafayette St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1602 Bolton St* ST. *14* WARD)

2-FULL NAME

Jacob Helmling Furst
(Residence in Baltimore: No. *1602 Bolton St* St.; yrs., mos. ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)6-DATE OF BIRTH, *Oct 14*, 18*61*
(Month) (Day) (Year)7-AGE, *53* yrs., *9* mos., *1* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Printer*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *MD*PARENTS.
10-NAME OF FATHER, *Joseph Furst*
11-BIRTHPLACE OF FATHER (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER, *Sophia Helmling*
13-BIRTHPLACE OF MOTHER (State or Country), *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Furst*
(Address) *1602 Bolton St*15- JUL 14 1915
Filed..... 191.....
Burial Permit No.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 13*, 191*5*
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 4*, 191*5*, to *July 13*, 191*5*,
that I saw him alive on *July 13*, 191*5*,
and that death occurred, on the date stated above, at *3:30* p. m.

The CAUSE OF DEATH* was as follows:

Atrophic Corrosion
(Duration)..... yrs..... mos. ds.CONTRIBUTORY.....
(Secondary).....
(Duration)..... yrs..... mos. ds.(Signed) *Chas. J. Hunter*
..... 191*5* (Address) *548 N. W. St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos. ds. In the State..... yrs..... mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cathedral *July 16*, 191*5*

20-UNDERTAKER, ADDRESS

M. Maher & Son *606 Lafayette*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asy.*)ST. *104* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Dorothy Haines(Residence in Baltimore: No. *St. Vincent's Infant Asylum*)St.; yrs., *11* mo., *20* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED, *single*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July *23*, *1914*.
(Month) (Day) (Year)

7-AGE,

yrs. *11* mos. *20* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUL 14 1915

DEERT KRAUTER

Filed *606121* Permit *0107* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July *13*, *1915*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 9th *1915*, to *July 13* *1915*,that I saw her alive on *July 13* *1915*,and that death occurred, on the date stated above, at *1205* m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis(Duration) yrs. mos. *5* ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. E. Boulton* M. D.*July 13*, *1915* (Address) *615 Colverton Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *11* mos. *20* ds. In the State yrs. *11* mos. *20* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral**July 14*, *1915*

20-UNDERTAKER

ADDRESS

M. F. Hayes & Sons 606 Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.: *14* WARD)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs. *10* mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Sept. 14, 1914
(Month) (Day) (Year)

7-AGE,

yrs. *10* mos. ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*md.*

PARENTS.

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *S. J. Vincent*(Address) *1701 Division St.*

JUL 14 1915

Filed *1915* *Robert Krauter* Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 13, 1915, to July 14, 1915
that I saw her alive on *July 13, 1915*and that death occurred, on the date stated above, at *4:00 a.m.*

The CAUSE OF DEATH* was as follows:

Gastro-enteritis(Duration) yrs. mos. ds. *1 ds.*CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. P. Sullivan* M. D.*July 14, 1915* (Address) *615 Columbus Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *9* mos. *12* ds. In the State yrs. *10* mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral *July 14, 1915*

20-UNDERTAKER

ADDRESS

M. Mahoney & Sons 607 Lafayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asy.* ST. *14* WARD)

2-FULL NAME

Mark Philips

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs. *1* mos. *23* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED, *Single*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May 20th, 1915
(Month) (Day) (Year)

7-AGE,

*1 mos. 23 ds.*If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*St. Vincent's*(Address).....*1401 Division St.*

15-

FILED

JUL 14 1915

JOSEPH KRAUTER

Regist. Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 13, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1st 1915, to July 13 1915,
that I saw him alive on *July 13 1915,*and that death occurred, on the date stated above, at *11th A. M.*

The CAUSE OF DEATH* was as follows:

M. tuberculosis(Duration).....yrs. *1* mos. *20* ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.mos.ds.

(Signed).....*J. P. Sullivan* M. D.*July 13, 1915* (Address).....*615 Columbus Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *10* ds. In the State yrs. *1* mos. *23* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral**July 14, 1915*

20-UNDERTAKER

ADDRESS

M. Fahy & Sons 606 Lafayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum*)ST. *14*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Stone(Residence in Baltimore: No. *St. Vincent's Infant Asylum*)St.; yrs. *1* mos. *10* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-RINGLE,
MARRIED, SINGLE,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May 30, 1915
(Month) (Day) (Year)

7-AGE,

1 mos. 12 da.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

PARENTS.

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUL 14 1915

ROBERT KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1st* 1915, to *July 12* 1915, that I saw him alive on *July 12* 1915, and that death occurred, on the date stated above, at *11:30* m.

The CAUSE OF DEATH* was as follows:

Inebriation
(Duration) yrs. *1* mos. *10* da.CONTRIBUTORY
(Secondary)(Signed) *J. Poulton* M. D.
(Address) *615 Columbian Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *1* mos. *10* da. In the State yrs. *1* mos. *12* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral July 14, 1915

20-UNDERTAKER

ADDRESS

M. F. Talley & Sons 602 Lafayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86683

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86683

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 413 E. Jutting

ST. 104 WARD)

2-FULL NAME

Lehman Franklin Mox.

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 18.)

(Residence in Baltimore: No. 413 E. Jutting

St. 1 yrs. - mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

June 17

(Month)

(Day)

1914 (Year)

7-AGE

1 yrs. -

mos. 26

ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Unemployed

9-BIRTHPLACE

(State or country)

Baltimore Md.

10-NAME OF FATHER

Frederick L. Mox

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Eva A. Mox

13-BIRTHPLACE OF MOTHER
(State or country)

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frederick L. Mox

(Address)

413 E. Jutting St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 13

(Month)

(Day)

1914 (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 12, 1914, to July 13, 1914,

that I saw him alive on July 13, 1914,

and that death occurred, on the date stated above, at 9:50 p.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

Contributory
(SECONDARY)

(Duration)

yrs

mos.

ds.

(Signed)

Robert R. Schick

M. D.

July 14, 1914 [Address] 1318 P. Charles St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Weston Cemetery

July 15, 1914

20-UNDERTAKER

ADDRESS

Mr. J. Talbot

1318 P. Charles St.

15- JUL 14 1915

Filed

REGISTRAR

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;.....WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.;yrs.mos.ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....

191.....

Marial Permit 010.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

June 6 1915, to July 13, 1915,

that I saw her alive on July 13, 1915,

and that death occurred, on the date stated above, at 11/16th m.

The CAUSE OF DEATH* was as follows:

Primary Bright's

Immediate - Exhaustion.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

7/14/15 (Address) 506 Belvoir St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel St

July 16, 1915

20-UNDERTAKER

ADDRESS

L & Brown & Son

127 W. Mather

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.; *23* WARD)

2-FULL NAME

(Residence in Baltimore: No. *915 Plum Alley* St.; — yrs., — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Apr. 17, 1884
(Month) (Day) (Year)

7-AGE,

31 yrs. 2 mos. 26 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Stenographer*9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUL 15 1915 HARRY O. ANDREWS

Filed..... 1915..Burial Permit 01614

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 13, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 28, 1915*, to *July 13, 1915*,that I saw him alive on *July 13, 1915* and that death occurred, on the date stated above, at *10:25 P.M.*

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Chorea
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)(Duration)..... yrs..... mos..... ds.
(Signed)..... *Edward J. Smith* M. D.
July 28, 1915 (Address)..... *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? *915 Plum Alley*Former or usual residence *915 Plum Alley*

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn *July 16, 1915*

20-UNDERTAKER

L. E. Brownson *108 N. Mount*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48

C86635

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Home of Mrs. Garrett* ST.: *42* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary E. Garrett*(Residence in Baltimore: No. *2211a Guilford Ave* St.: *2* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*6-DATE OF BIRTH *Sept 16, 1840*

(Month)

(Day)

(Year)

7-AGE *74*yrs. *9* mos. — ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Virginia*10-NAME OF FATHER *Peter W. Simpson*11-BIRTHPLACE OF FATHER (State or Country), *Don't know*12-MAIDEN NAME OF MOTHER *Don't know*13-BIRTHPLACE OF MOTHER (State or Country), *Don't know*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Howard M. Garrett*(Address) *3938 Old York Rd*

15-

Filed *JUL 15 1915*

Y01

HARRY O. ANDREWS,
Baptist Permit. Officer
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 13, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 16* 1915, to *July 13* 1915, that I saw her alive on *July 13* 1915, and that death occurred, on the date stated above, at *8:30 p.m.*

The CAUSE OF DEATH* was as follows:

Arthritis Deformans
Duration a number of years
exact unknown (Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY *Exhaustion due to heart*
(Secondary)and *Age* (Duration) ... yrs. ... mos. ... ds.
(Signed) *Harrison G. Cooper* M. D.
July 13, 1915. (Address) *2422 St Paul St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs. ... mos. ... ds. In the *74* yrs. ... mos. ... ds. State *74* yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence *2922 E. 1st St*19-PLACE OF BURIAL OR REMOVAL, *St. Paul*DATE OF BURIAL, *July 15, 1915*20-UNDERTAKER *William Cook*ADDRESS *502 E. 1st St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *449 E. 22nd*)ST.: *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Minnie B. Greves*(Residence in Baltimore: No. *449 E 22nd*)St.: *57* yrs., *11* mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH

Aug 14, 1857
(Month) (Day) (Year)

7-AGE

57 yrs., *11* mos. — da.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework at home

9-BIRTHPLACE, (State or Country),

Baltimore City

10-NAME OF FATHER

Henry Snyder

11-BIRTHPLACE OF FATHER

Germany

12-MAIDEN NAME OF MOTHER

Mary Rife

13-BIRTHPLACE OF MOTHER

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George Snyder*(Address) *449 E. 22nd*

15-

JUL 15 1915 HARRY O. ANDREWS,
Filed..... 191-*21st* Permit. *OL*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 2nd 1915, to *July 14 1915*,that I saw her alive on *July 13 1915*,and that death occurred, on the date stated above, at *2.30 p m.*

The CAUSE OF DEATH* was as follows:

Vascular Heart Lesions..... (Duration) *2* yrs. mos. da.CONTRIBUTORY.....*Exhaustion*.....
(Secondary)..... (Duration) yrs. mos. *1.2* da.(Signed) *J. W. ...* M. D.*July 14 1915* (Address) *115 S. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore 191...

20-UNDERTAKER

ADDRESS

William Cook *502 E. 11th*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

86688

HEALTH DEPARTMENT—CITY OF BALTIMORE

86688

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 N. Bruce

ST. 19 WARD)

REGISTERED NO. C

FULL NAME

Publius A Boston (Boston)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 12 N. Bruce

St.: yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widowed

6-DATE OF BIRTH,

July 10th, 1853
(Month) (Day) (Year)

7-AGE,

62 yrs. 29 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

house wife

9-PLACE,

(State or Country),

md

10-NAME OF FATHER,

Levigillis

11-BIRTHPLACE OF FATHER

(State or Country),

md

12-MAIDEN NAME OF MOTHER

Eliza Fisher

13-BIRTHPLACE OF MOTHER

(State or Country),

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Emma Garrett

(Address)

831 Bruce St.

15-

JUL 15 1915

HARRY O. ANDREWS,

Filed

1915 Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ~~June 30~~ 1915, to July 12 1915, that I saw him alive on July 11 1915, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Banatilis

(Duration) yrs. 2 mos. 12 ds.

CONTRIBUTORY (Secondary)

2. heart

(Duration) yrs. 3 mos. 3 ds.

(Signed) C. H. H. M. D.

July 12, 1915 (Address) 712 S. Bay St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Laurel anthy

July 15 1915

20-UNDERTAKER

ADDRESS

Alfred J. Ireland

1148 S. Charles

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No

ST.:

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; 56 yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

Don't know

1860

7-AGE

55

If LESS than

1 day, hrs.,

ds. or min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Laborer

General

9-BIRTHPLACE

(State or country)

Eastern Shore Md

10-NAME OF FATHER

Henry Nichols

11-BIRTHPLACE OF FATHER

(State or country)

Eastern Shore Md

12-MAIDEN NAME OF MOTHER

Elsy Gladden

13-BIRTHPLACE OF MOTHER

(State or country)

Eastern Shore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elsy Nichols

(Address)

1346 Carroll St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 12, 1915

17-I HEREBY CERTIFY, That I attended deceased from

Feb 1, 1914, to July 12, 1915

that I saw him alive on July 10, 1915

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

General Arterio-Sclerosis

Contributory (SECONDARY)

(Signed)

A. J. M. East 7/14, 1915 [Address] 2005 Russell Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount Airy

July 15, 1915

20-UNDERTAKER

ADDRESS

John A. Owen

1222 Union

JUL 15 1915

Filed

191

REGISTRAR

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86690

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86690

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (NO. 1035 Wilmer alley, ST. 17 WARD)

FULL NAME George H. Wilson,

(Residence in Baltimore: No. 1035 Wilmer alley,

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number; and fill out No. 18.)

St.; yrs., 1 mos. / 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, May 28th, 1915. (Month) (Day) (Year)

7-AGE, 0 yrs., 1 mos., 16 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS. 10-NAME OF FATHER, James Wilson, 11-BIRTHPLACE OF FATHER (State or Country), Virginia, 12-MAIDEN NAME OF MOTHER, Daisy Butler, 13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daisy Wilson, mother,

(Address) 1035 Wilmer alley.

15- JUL 15 1915 HARRY O. ANDREWS, Registrar. Filed 191

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 14th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastroenteritis, (Duration) yrs. mos. ds.

CONTRIBUTORY Artificial feeding, (Secondary)

(Signed) J. Frederick Kempel, M. D. (Coroner.) July 14, 1915. (Address) 3310 W. North av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Mt Auburn Cemetery, July 15, 1915

20-UNDERTAKER, ADDRESS, Walter Owens, 235 Paul st

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1023 Wilcox*)ST.: *10* WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1023 Wilcox*)St.: *2* yrs., *5* mos. *22* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH,

January 22nd 1913
(Month) (Day) (Year)

7-AGE,

2 yrs., *5* mos. *22* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore Md.

PARENTS.

10-NAME OF FATHER,

Samuel Denhardt

11-BIRTHPLACE OF FATHER (State or Country),

city.

12-MAIDEN NAME OF MOTHER

Annie Fisher

13-BIRTHPLACE OF MOTHER (State or Country),

city.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Sam. Denhardt*(Address) *1023 Wilcox St.*15- *JUL 15 1915*

Filed

191

Serial Permit 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1 1915*, to *July 14 1915*, that I saw him alive on *July 14 1915*, and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH* was as follows:

Double Lobar pneumonia
(Double Sup. otitis media)
(7 days) suppuration
(Duration) ... yrs. ... mos. *13* ds.

CONTRIBUTORY (Secondary)

(Signed) *E. H. Haywood* M. D.
7/15 1915 (Address) *838 E. Preston*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Mary's Cemetery (Evening)

DATE OF BURIAL,

July 15 1915

20-UNDERTAKER

Henry Harkness

ADDRESS

1301 E. Egan St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 C86692
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2436 Eager Place* ST.;

2-FULL NAME

(Residence in Baltimore: No. *2436 Eager Place*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *5* yrs., *10* mos., *26* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Single

6-DATE OF BIRTH.

August 28, 1909
(Month) (Day) (Year)

7-AGE.

5 yrs., *10* mos., *26* da.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.

(State or Country).

Ballo. md.

10-NAME OF FATHER.

Frank A. Roberts

11-BIRTHPLACE OF FATHER.

(State or Country).

Ballo. md.

12-MAIDEN NAME OF MOTHER.

Catherine Huber

13-BIRTHPLACE OF MOTHER.

(State or Country).

Ballo. md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. Frank A. Roberts

(Address)

2436 Eager Place

15-

*JUL 15 1915**HARRY O. ANDREWS*

Filed

191

Serial Permit 0191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 14, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *June 30* 1915, to *July 13* 1915.that I saw him alive on *July 13* 1915.and that death occurred, on the date stated above, at *4:20* a.m.

The CAUSE OF DEATH* was as follows:

Acute Poisoning from eating Crabs.
(Duration) ... yrs. ... mos. *14* da.

CONTRIBUTORY (Secondary)

Acute Indigestion
(Duration) ... yrs. ... mos. *14* da.
(Signed) *J. A. Collier* M. D.
1810 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Redeemer

DATE OF BURIAL.

July 16, 1915

20-UNDERTAKER

Henry Kuehn & Son

ADDRESS

1301 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86693

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86693

CERTIFICATE OF DEATH

108
REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

Hebrew Hospital

ST. 10 WARD)

Mary Hoffman

1020 East Chase

St.; 64 yrs. 8 mos. 15 da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

White

Widow

6 DATE OF BIRTH

October

28

1950

7 AGE

about 64 yrs.

8 mos.

15 ds.

IF LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

9 BIRTHPLACE

(State or country)

Baltimore Md.

10 NAME OF FATHER

John Busch

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER

(State or country)

Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Joseph Hoffman

(Address)

1020 East Chase St.

15 JUL 15 1915

HARRY O. ANDREWS,

Filed

1915

Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

13, 1915

Month

Day

Year

17. I HEREBY CERTIFY, That I attended deceased from

July 12, 1915, to, July 13, 1915.

that I saw her alive on July 13, 1915.

and that death occurred, on the date stated above, at 4:00 p.m.

The CAUSE OF DEATH* was as follows:

acute appendicitis with peritonitis

(Duration)

yrs.

mos.

5 ds

Contributory

(SECONDARY)

uremia

(Duration)

yrs.

mos.

1 ds.

(Signed)

M. B. Keene

M. D.

July 13, 1915.

(Address)

Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

1 ds.

In the

State

64 yrs.

8 mos.

15 ds.

Where was disease contracted, if not at place of death?

1020 East Chase St.

Former or

usual residence

1020 East Chase St.

19 PLACE OF BURIAL OR REMOVAL

Holy Redeemer Cemetery

DATE OF BURIAL

July 16, 1915

20 UNDERTAKER

Henry Hockley

ADDRESS

1301 E. 34th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *430 W. Biddle* ST.; *11* WARD)

2-FULL NAME

(Residence in Baltimore: No. *430 W. Biddle* St.; *25* yrs., *2* mos., *5* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*married*

6-DATE OF BIRTH.

Unknown, *1847*
(Month) (Day) (Year)

7-AGE.

*68**—* yrs., *—* mos., *—* ds.

If LESS than 1 day.

— hrs. or *—* min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Physician*9-BIRTHPLACE,
(State or Country).*Da*

10-NAME OF FATHER.

*Nutshell Cargill*11-BIRTHPLACE OF FATHER
(State or Country).*Da*

12-MAIDEN NAME OF MOTHER

*Ellen Cargill*13-BIRTHPLACE OF MOTHER
(State or Country).*Da*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Iola Cargill

(Address).

430 W. Biddle St

15-

Filed.

JUL 15 1915

HARRY O. ANDERSON

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 13, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 25* 1915, to *July 13* 1915, that I saw him alive on *July 13* 1915, and that death occurred, on the date stated above, at *6:00* p.m.

The CAUSE OF DEATH* was as follows:

*Arterio-sclerosis*CONTRIBUTORY
(Secondary)*Pulmonary edema*
(Duration) yrs. *2* mos. *—* ds.

(Signed)

W. J. Carl M. D.*July 13, 1915* (Address) *515 North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Mt. Auburn Cem.

DATE OF BURIAL.

July 16, 1915

20-UNDERTAKER

George W. Hollis

ADDRESS

1717

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86695

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86695

PLACE OF DEATH

St Francis Convent

CERTIFICATE OF DEATH

105

REGISTERED NO. C

CITY OF BALTIMORE (No.)

Forrest & Chase

ST.

10

WARD)

2-FULL NAME

Eleanora Watkins

(Residence in Baltimore: No.)

Forrest & Chase

St. 2 yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6 DATE OF BIRTH April 30, 1909 (Month) (Day) (Year)

7 AGE 6 yrs. 2 mos. 14 ds. or less than 1 day, hrs. min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) New York State

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mother M. Frances O.S.P. St Francis Convent Chase St & Forrest Pl.

(Address)

JUL 15 1915

HARRY O. ANDERSON

RACIAL FORM REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1914 to July 1915 that I saw her alive on July 12, 1915 and that death occurred, on the date stated above, at 5.10 p.m. The CAUSE OF DEATH* was as follows:

Gastro Enteritis Marasmus alt 1 yrs. mos. ds. Contributory Asthma (SECONDARY) (Duration) yrs. mos. ds. (Signed) Mary F. Vaughan M.D. July 14, 1915 (Address) 1028 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 2 yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, if not at place of death? Forrest & Chase St. Former or usual residence Forrest & Chase St.

19 PLACE OF BURIAL OR REMOVAL Holy Cross Cemetery DATE OF BURIAL July 15, 1915

20 UNDERTAKER Felix B. Pye ADDRESS 1028 Mulligan St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *304 N. Eden* ST. *5* WARD)

2-FULL NAME *Hilda Miller*

(Residence in Baltimore: No. *304 N. Eden* St. *-* yrs. *10* mos. *-* ds.)

REGISTERED NO. C. *104*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

female

4-COLOR OR RACE

colored

5-SINGLE

single

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

Oct

(Month)

14

(Day)

1914

(Year)

7-AGE

If LESS than

1 day, hrs.

yrs. *10* mos. *-* ds. or *mic.*?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Baltimore City

10-NAME OF FATHER

Calvin Wesley

11-BIRTHPLACE OF FATHER

(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Carrie Miller

13-BIRTHPLACE OF MOTHER

(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carrie Miller

(Address)

304 N. Eden St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July

14

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 2*, 191*5*, to, *July 14*, 191*5*,

that I saw her alive on *July 14*, 191*5*,

and that death occurred, on the date stated above, at *8 A* m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration)

yrs

mos

12 ds.

Contributory (SECONDARY)

Spasms

(Duration)

yrs

mos

2 ds.

(Signed)

M. H. Harris

M. D.

July 13, 191*5* [Address] *1416 Jefferson*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs

mos

ds.

In the

yrs

mos

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Laurel Cn.

DATE OF BURIAL

July 15, 191*5*

20-UNDERTAKER

Mrs. J. G. Gable

ADDRESS

1302 Jefferson

JUL 15 1915

Filed

191

HARRY O. ANDERSON,

Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.; *21* WARD)FULL NAME *Lula V. Livingston*(Residence in Baltimore: No. *1101 W. Cross St.* St.; — yrs., — mos., — ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Aug 25, 1887
(Month) (Day) (Year)

7-AGE,

*27 yrs. 10 mos. 19 ds.*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Homemaker*
*General*9-BIRTHPLACE,
(State or Country),*MD.*

10-NAME OF FATHER,

*Lewis Vogel*11-BIRTHPLACE OF FATHER
(State or Country),*MD.*

12-MAIDEN NAME OF MOTHER

*Lula Wilson*13-BIRTHPLACE OF MOTHER
(State or Country),*MD.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James N. Livingston*(Address) *1101 W. Cross St.*

15-

JUL 15 1915

HARRY O. ANDREWS,

Filed..... 191..... *Partial Permit* *Alar*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 14, 1915, to July 15, 1915*that I saw her alive on *July 15, 1915*and that death occurred, on the date stated above, at *2:00 p.m.*

The CAUSE OF DEATH* was as follows:

*Child Birth at term*CONTRIBUTORY
(Secondary)(Duration) *Placenta previa with*
hemorrhage 2 1/2 hrs.(Signed) *Edward S. Smith**July 15, 1915* (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *12 hrs.* In the *State* *MD.* yrs. mos. ds.Where was disease contracted, if not at place of death? *1101 W. Cross St.*Former or usual residence *1101 W. Cross St.*

19-PLACE OF BURIAL OR REMOVAL,

Bedar Hill Cemetery

DATE OF BURIAL,

July 17, 1915

20-UNDERTAKER

Armstrong Denny Co

ADDRESS

715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Still Birth 2877

C86698

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 C86698

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3019 Independent ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lilly E. Werking(Residence in Baltimore: No. 3019 Independent St.; 9 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE White5-STATUS: Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, July (Month) 13 (Day), 1891 (Year)7-AGE, 24 yrs., — mos., — ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Home duties

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Harford Co. Md

PARENTS.

10-NAME OF FATHER, Henry Lapp11-BIRTHPLACE OF FATHER (State or Country), Balto12-MAIDEN NAME OF MOTHER Lessa W. Hild13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUL 15 1915 HARRY O. ANDREWS,
Filed..... 1915. 151. Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 13 (Day), 1914 (Year)I HEREBY CERTIFY, That I attended deceased from May 31st 1915, to July 13 1915, that I saw h alive on July 12 1915, and that death occurred, on the date stated above, at 7-30 a.m. The CAUSE OF DEATH* was as follows:Pulmonary Tuberculosis
(Duration) 1 yrs., 10 mos., — ds.

CONTRIBUTORY (Secondary).....

(Signed) M. A. Farver M. D.
July 15, 1915. (Address) 12 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the — State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London ParkDATE OF BURIAL, July 10, 191520-UNDERTAKER William CookADDRESS 2502 E. 25th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *Union Prot. Infirmary 14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Norfolk Va.*St.;yrs.,mos. *8* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *female* 4-COLOR, OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)

6-DATE OF BIRTH,

Sept 4
July 15, 1867
(Month) (Day) (Year)

7-AGE,

47 yrs. *10* mos.ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Rum maker*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

John G. Martin

11-BIRTHPLACE OF FATHER (State or Country),

Balt. Md.

12-MAIDEN NAME OF MOTHER

Emma Galvin

13-BIRTHPLACE OF MOTHER (State or Country),

Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Allen Granbery*(Address) *112 N. Mulberry St.*

15-

JUL 15 1915

JOSEPH KRAUTER

Filed

191

SEP 12 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 8 1915, to *July 15* 1915, that I saw her alive on *July 15* 1915, and that death occurred, on the date stated above, at *4 P* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Coronary Thrombosis(Duration) *5* yrs.mos.ds.

CONTRIBUTORY (Secondary)

Coronary Thrombosis

(Duration)yrs.mos.ds.

(Signed) *Bernard S. Chaffin* M. D.*July 15*, 1915 (Address) *Union Prot. Inf.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos. *8* ds. In the Stateyrs.mos.ds.Where was disease contracted, if not at place of death? *Norfolk Va.*Former or usual residence *Norfolk Va.*

19-PLACE OF BURIAL OR REMOVAL,

Norfolk Va.

DATE OF BURIAL,

July 16 1915

20-UNDERTAKER

W. L. Smith & Son

ADDRESS

Remond North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *g. H. Hospital*

ST.;

WARD) *2*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

James Williams(Residence in Baltimore: No. *247 Washington St.**Baltimore* St.;

yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

February 29

(Month)

(Day)

1915 (Year)

7-AGE,

4 yrs. 16 mos. 16 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

Infant

9-BIRTHPLACE,

(State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Samuel Williams

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Clara Browning

13-BIRTHPLACE OF MOTHER

(State or Country),

Ala

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

g. H. Hospital

(Address)...

S. T. Hilbert

15-

JUL 15 1915

Filed

Permit 0107

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15

(Month)

(Day)

1915 (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 9 1915, to *July 15* 1915,that I saw him alive on *July 15* 1915,and that death occurred, on the date stated above, at *5 P.M.*

The CAUSE OF DEATH* was as follows:

Indigestion, Intestinal, Acute(Duration).....yrs.....mos...*8* ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *G. A. Batten* M. D.*July 15, 1915* (Address) *J. H. Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos...*6* ds. In the State.....yrs...*4* mos...*16* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *247 S. Washington St.*

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill

DATE OF BURIAL,

July 16, 1915

20-UNDERTAKER

Rudell Lippel Son

ADDRESS

330 S. Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

S 86702

CERTIFICATE OF DEATH.

108 C86702

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital*);

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *George Groth**30 E. Randall St*St.; *19* yrs., *4* mos., *13* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Single*

6-DATE OF BIRTH.

*May**1st**1896*

(Month)

(Day)

(Year)

7-AGE.

*19**4**13*

yrs. mos. ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

*General*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Henry Groth*11-BIRTHPLACE OF FATHER
(State or Country),*MD*

12-MAIDEN NAME OF MOTHER

*Elizabeth Shum*13-BIRTHPLACE OF MOTHER
(State or Country),*MD.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

*Mr. Chas. Groth**30 E. Randall St*

15-

JUL 15 1915

Filed.....

HARRY KRAUTER

MAY 1st 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

*July**14**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 12**1915*

to

*July 14**1915*

that I saw him alive on

*July 14**1915*and that death occurred, on the date stated above, at *3:50* p.m.

The CAUSE OF DEATH* was as follows: ,

Abscess of Lung
and Emphysema

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY

(Secondary)

Peritonitis

(Duration)..... yrs..... mos..... ds.

(Signed).....

*R. L. Johnson**7/14**1915*

(Address).....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

of death.....

yrs.....

mos.....

In the

State.....

yrs.....

mos.....

ds.....

Where was disease contracted,

if not at place of death?

Baltimore

Former or

usual residence.....

30 E. Randall St

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Mary's Cem.**July 17*

20-UNDERTAKER

ADDRESS

*Joe R. Cook**1003 N. Balto*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86703

CERTIFICATE OF DEATH.

C86703

PLACE OF DEATH

CITY OF BALTIMORE (No. 1577 N Durham

ST. 8

WARD)

REGISTERED No. C

FULL NAME

Hilda L Miller

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1577 N Durham

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *June 15, 1913* (Month) (Day) (Year)

7-AGE, *1* yrs., *1* mos., *1* ds. IF LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Infant* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *MD*

10-NAME OF FATHER, *Geo H Miller*

11-BIRTHPLACE OF FATHER, (State or Country), *MD*

12-MAIDEN NAME OF MOTHER, *Margaret Keeney*

13-BIRTHPLACE OF MOTHER, (State or Country), *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George H Miller*

(Address) *1577 Durham St*

15- *JUL 15 1915* *PERMIT CLERK*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 15, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) And that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) *Insulted Convulsions*

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Edgar J Russell* M. D. (Coroner)

July 15, 1915 (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF FUNERAL OR BURIAL, DATE OF BURIAL, *July 16, 1915*

St. Casimir ADDRESS *1442 N. Brady*

Rebecca L. Lane

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Dams from (Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Signed) M. D.

July 14, 1915. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86705

HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH

C86705

8

PLACE OF DEATH

CITY OF BALTIMORE (No. ~~111~~ 409 Moore St.)

FULL NAME *Henrietta Clay*

(Residence in Baltimore: No. *409 Moore Alley*)

79
REGISTERED No. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str. — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *widow*
(Write the word)

6-DATE OF BIRTH *unknown*, 1850
(Month) (Day) (Year)

7-AGE *65*
yrs. mos. ds. or — mo. ? If LESS than 1 day, hrs.

8-OCCUPATION
(a) Trade, profession, or particular kind of work *Laundress at home*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Maryland*

PARENTS

10-NAME OF FATHER *John Jackson*

11-BIRTHPLACE OF FATHER (State or country) *Maryland*

12-MAIDEN NAME OF MOTHER *Mary Harden*

13-BIRTHPLACE OF MOTHER (State or country) *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Chas. Clay*
(Address) *409 Moore Alley*

15 JUL 16 1915
Filed
HARRY O. ANDREWS,
Serial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 14*, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Apr 4*, 1915, to *July 14*, 1915, that I saw her alive on *July 13*, 1915, and that death occurred, on the date stated above, at *m.*
The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) yrs. mos. ds. *2*
Contributory *Metabolical*
(SECONDARY) *disorder*
(Signed) *Wm E Burton* M. D.
July 15 1915 (Address) *762 Drexel*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Mt Auburn Cemetery*
20-UNDERTAKER *Felix B. Pye*
DATE OF BURIAL *July 18*, 1915
ADDRESS *1018 Mulberry St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86706

C86706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Womans Hospital*)ST.; *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mrs Emma Giddings*(Residence in Baltimore: No. *613 St Paul*)St. *25* yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-MINGLE,
MARRIED, *married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Jan 12 1854
(Month) (Day) (Year)

7-AGE,

61 yrs. *6* mos. *13* da.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

*Lady*9-BIRTHPLACE,
(State or Country),*Virginia*10-NAME OF
FATHER,*Daniel List*11-BIRTHPLACE
OF FATHER
(State or Country),*Wheeling W. Va.*12-MAIDEN NAME
OF MOTHER*Miss Heissen*13-BIRTHPLACE
OF MOTHER
(State or Country),*Winchester Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. M. Gardner*(Address) *Womans Hospital*

15-

Filed

*JUL 16 1915**HARRY O. ANDREWS,**191 Serial Permit. Al.*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 12 1915, to *July 16 1915*,that I saw her alive on *July 16 1915*,and that death occurred, on the date stated above, at *5:45 am*.

The CAUSE OF DEATH* was as follows:

*Acute Appendicitis with
Peritonitis*

(Duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) *A. P. Jones* M. D.*July 16, 1915* (Address) *Womans Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State *25* yrs. mos. da.Where was disease contracted, if not at place of death? *Riverton Md*Former or usual residence *613 St Paul*

19-PLACE OF BURIAL OR REMOVAL.

Greenmount Cem

DATE OF BURIAL,

July 18 1915

20-UNDERTAKER

Henry W. Jenkins & Sons Co *McLulloch & Orchard*

N. E.—Every item of information herein is carefully supplied. AGE, INQUIRY BE MADE EXACTLY. THIS SIGNATURE SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

086707

HEALTH DEPARTMENT—CITY OF BALTIMORE

086707

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *1025 Madison Ave.*)

145
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2 FULL NAME

Mary Elizabeth Tumbleson

ST. *11* WARD)

(Residence in Baltimore: No. *1025 Mad. Ave.*)

St. *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word)

6 DATE OF BIRTH *April 20, 1857*
(Month) (Day) (Year)

7 AGE *58* yrs. *2* mos. *24* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Baltimore

PARENTS

10 NAME OF FATHER *Benjamin Roydon Gayle*

11 BIRTHPLACE OF FATHER
(State or country) *Virginia*

12 MAIDEN NAME OF MOTHER *Charlotte Hill*

13 BIRTHPLACE OF MOTHER
(State or country) *England*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Robert J. Tumbleson*
(Address) *1025 Mad. Ave.*

15 JUL 16 1915

HARRY O. ANDREWS
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 14, 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from *May 28, 1915* to *July 14, 1915* that I saw her alive on *July 14, 1915* and that death occurred, on the date stated above, at *5:05 P.M.*
The CAUSE OF DEATH* was as follows:

*acute universal
Exfoliating dermatitis*

Contributory *High grade of intoxication acidosis from the chronic condition*
(Duration) yrs. mos. *40* ds.
(Signed) *John A. Lutscher* M. D.
July 15, 1915 (Address) *1025 Mad. Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Landon Park* DATE OF BURIAL *July 16, 1915*

20 UNDERTAKER *Chas. E. Francis* ADDRESS *802 Madison Ave.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86708

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86708

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

1933 Vine

ST.

19

WARD)

2-FULL NAME

Franz Kuhubeger

(Residence in Baltimore: No.

1933 Vine

St.

30

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Nov

10, 1858

(Month)

(Day)

(Year)

7 AGE

57

yrs.

8

mos.

4

ds.

If LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Hostler

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Germany

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER

(State or country)

Not known

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER

(State or country)

Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rose Kuhubeger

(Address)

1933 Vine St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

14

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 13, 1915, to July 14, 1915,

that I saw him alive on July 14, 1915,

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar

(Duration)

yrs.

mos.

2

ds

Contributory

(SECONDARY)

Coronary Embolism

(Duration)

yrs.

mos.

1

ds

(Signed)

Joseph E. Glicker

M. D.

July 15, 1915

(Address)

1516 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Resurrection Burial

July 17, 1915

20 UNDERTAKER

ADDRESS

Wm. E. Carter

916

JUL 16 1915

HARRY O. ANDREWS,

Registrar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 538 Orchard street, ST. 17 WARD)

FULL NAME Junius Jackson,

(Residence in Baltimore: No. 538 Orchard street,

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., 5 mos. / 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male,

4-COLOR OR RACE,

Colored,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single,

6-DATE OF BIRTH,

January 27th., 1915.
(Month) (Day) (Year)

7-AGE,

0 yrs., 5 mos., 18 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None.

9-BIRTHPLACE,
(State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

William Jackson,

11-BIRTHPLACE OF FATHER

(State or Country), Maryland,

12-MAIDEN NAME OF MOTHER

Clara Hounsby,

13-BIRTHPLACE OF MOTHER

Virginia,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Hounsby, mother,

(Address) 538 Orchard street,

15- JUL 16 1915

HARRY O. ANDREWS,

Filed....., 191.....

Sanial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15th., 1915.
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Enteritis.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY Artificial feeding,
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. Frederick Campbell, M.D.

(Coroner.)

July 15., 1915 (Address) 3310 W. North av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86710

586710

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *650 Aull*
 CITY OF BALTIMORE: (No. *9* ST.; *9* WARD)
 2-FULL NAME *Leslie L Lewis*
 (Residence in Baltimore: No. *650 Aull* St.; *1* yrs., *3* mos. *23* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Col* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
 6-DATE OF BIRTH, *March 22, 1914*
 (Month) (Day) (Year)
 7-AGE, *1* yrs., *3* mos., *23* ds. If LESS than 1 day, ... hrs. or ... min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *None*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*
 10-NAME OF FATHER, *Jennie Lewis*
 11-BIRTHPLACE OF FATHER, (State or Country), *Virginia*
 12-MAIDEN NAME OF MOTHER, *Carrie B. Jones*
 13-BIRTHPLACE OF MOTHER, (State or Country), *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *Carrie B. Lewis*
 (Address) *650 Aull St.*

15- JUL 16 1915.
 Filed *101* HARRY O. ANDREWS,
 Social Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 14, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 5, 1915*, to *July 14, 1915*, that I saw him alive on *July 14, 1915*, and that death occurred, on the date stated above, at *9* p. m.

The CAUSE OF DEATH was as follows:

Cute Bronchitis
 (Duration) *15* yrs. *15* mos. *15* ds.

CONTRIBUTORY (Secondary) *Nothing*

(Signed) *P. Garland Whitely* M. D.
July 1, 1915 (Address) *424 East 23*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *3* mos. *23* ds. In the State *1* yrs. *3* mos. *23* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Land Cemetery* DATE OF BURIAL, *July 16, 1915*

20-UNDERTAKER *John R. Owens* ADDRESS *1222*

16-2. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widower

6-DATE OF BIRTH,

Aug 17, 1830
(Month) (Day) (Year)

7-AGE,

84 yrs. 10 mos. 28 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Carpenter
Retired

9-BIRTHPLACE, (State or Country).

Pa

10-NAME OF FATHER,

Dont Know

11-BIRTHPLACE OF FATHER (State or Country),

Dont Know

12-MAIDEN NAME OF MOTHER

Dont Know

13-BIRTHPLACE OF MOTHER (State or Country),

Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Ada A Phillips
2212 Harford Ave

15- JUL 16 1915.

Filed..... 191.....

HARRY U. A. S. S.

BALTIMORE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 13, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1, 1915, to July 13, 1915,

that I saw him alive on July 13, 1915,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Old age

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... M. D.

July 14, 1915. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore

July 18, 1915.

20-UNDERTAKER

ADDRESS

William Cook

502 E. Hill

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; — yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 12 1915, to July 13 1915,

that I saw her alive on July 13 1915,

and that death occurred, on the date stated above, at 1:00 p.m.

The CAUSE OF DEATH* was as follows:

Purulent Salpingitis
and Ac. Appendicitis
(Duration) 70 hrs. 10 mos. 3 da.CONTRIBUTORY
(Secondary)

(Duration) 10 hrs. 10 mos. 3 da.

(Signed) Edward P. Smith M. D.

July 13, 1915 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 1/4 yrs. In the State 3 1/4 yrs. 10 mos. 3 da.

Where was disease contracted, if not at place of death? 367 W. Preston St.

Former or usual residence 367 W. Preston St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

C86713 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 248 S Washington ST.; 2 WARD)2-FULL NAME Michael Francis Kenealy(Residence in Baltimore: No. 248 S Washington St.; 5 yrs., 11 mos., 7 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH.

Aug. 7, 1860
(Month) (Day) (Year)

7-AGE.

34 yrs., 11 mos., 7 ds.If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Police
City Dept9-BIRTHPLACE.
(State or Country).Md. (Baltimore)

10-NAME OF FATHER.

Michael Kenealy11-BIRTHPLACE OF FATHER
(State or Country).Ireland

12-MAIDEN NAME OF MOTHER

Ellen Coughlan13-BIRTHPLACE OF MOTHER
(State or Country).Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Rose Kenealy

(Address)

248 S Washington

15-

Filed JUL 16 1915

HARRY W. ANDERSON

BALTIMORE, Md.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 14, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 9 1915, to July 13 1915, that I saw him alive on July 13 1915, and that death occurred, on the date stated above, at 7:10 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus(Duration) 2 yrs., 11 mos., 7 ds.CONTRIBUTORY
(Secondary)Gangrene heart(Duration) 4 yrs., 4 mos., 4 ds.(Signed) Darmon MacAlister M. D.Aug 14, 1915. (Address) 1822 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs., 11 mos., 7 ds. In the State 5 yrs., 11 mos., 7 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

New CathedralJuly 14 1915

20-UNDERTAKER

ADDRESS

John A. Moran & Co.Bank

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *Hoot of Broadway* ST.: *2* WARD)
2-FULL NAME *Joseph E. Schlerich*
(Residence in Baltimore: No. *2007 Eastern Ave* St.: yrs. *169* mos. *2* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
6-DATE OF BIRTH, *Sept 24, 1877*
(Month) (Day) (Year)
7-AGE, *37* yrs. *9* mos. *20* ds. If LESS than 1 day, ...hrs. or...min?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Mate on tug boat*
(b) General nature of industry, business, or establishment in which employed (or employer). *Tugboat Reile*

9-BIRTHPLACE, (State or Country), *Baltimore*

PARENTS.
10-NAME OF FATHER, *Joseph Schlerich*
11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*
12-MAIDEN NAME OF MOTHER, *Mrs. A. W. W. W.*
13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Schlerich*
(Address) *2067 Eastern Ave*

15-*JUL 16 1915.*

Filed....., 191.....

HARRY O. ANDERSON
Serial Permit Officer

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 14, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, thereon and from the evidence obtained by said inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.
(Signed) *D. W. Jones* M. D.
(Coroner.)
July 15, 1915 (Address) *3116 D. W. Jones St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Coke Loun Cemetery

July 17, 1915

20-UNDERTAKER

ADDRESS

Lilly & Ziem

408 S. Wolfe St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86715

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2722 Elliott ST.; 1 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2722 Elliott St. St.; 25 yrs., 8 mos., 27 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widow

6-DATE OF BIRTH.

Oct 14, 1833
(Month) (Day) (Year)

7-AGE.

81 yrs., 8 mos., 27 ds.

If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Retired

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Billmair

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Andrew F. Schuch

(Address)

2722 Elliott St.

15-

JUL 16 1915

Filed....., 191.....

HARRY C. ANDREWS,

Marial Paralel Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 13, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2 1915, to July 13 1915, that I saw her alive on July 12 1915, and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis
(Duration) yrs. mos. ds.

(Signed) M. J. McAnany M. D.

July 13, 1915. (Address) 839 S. Egleston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Trinity Cemetery

DATE OF BURIAL,

July 16, 1915.

20-UNDERTAKER

Lilly Zeiler

ADDRESS

403 S. Wolfe

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28
REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Bassey Lane ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Blunt(Residence in Baltimore: No. 210 Bassey Lane St.; — yrs., — mos., — ds.)
born to J. Blunt dit do Zebra Blunt

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>male</u>	4-COLOR OR RACE. <u>colored</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <u>Married</u> (Write the word.)
6-DATE OF BIRTH. <u>Unknown</u> , 1..... (Month) (Day) (Year)		
7-AGE. <u>59</u> yrs., — mos., — ds.		If LESS than 1 day. — hrs. or — min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer). <u>General</u>		

9-BIRTHPLACE.
(State or Country),Virginia
Pearl Blunt

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),Virginia
not known
Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R. Blunt(Address) 210 Bassey Lane

15-

JUL 16 1915

HARRY C. ANDREWS,

MAR 18 FORM Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 14, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 26 1915, to July 14 1915,
that I saw him alive on July 13 1915,
and that death occurred, on the date stated above, at 5:00 P m.

The CAUSE OF DEATH* was as follows:

Tuberular Hemiplegia
of lungs
(Duration) yrs. 2 mos. 1 ds.CONTRIBUTORY
(Secondary)Hemiplegia of lungs
(Duration) yrs. 2 mos. 1 ds.*Signed Dr. W. K. Kenna M. D.July 15 1915 (Address) 708 E. Enoch St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mt. Auburn July 16 1915

20-UNDERTAKER

ADDRESS

Fr. Edward W. Pye & Winters
ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

C86717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86717

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

Hebrew Hospital

Levy Abrams

104 N. Front St

REGISTERED NO. C

ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

St. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6-DATE OF BIRTH

July, 1864

7-AGE

51 yrs. mos. ds. IF LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Bailiff
Judge Marland

9-BIRTHPLACE (State or country)

Russia

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER (State or country)

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Levy

(Address)

1414 E. Balt St

JUL 16 1915

Filed

191

HARRY O. ANDERSON

Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 15, 1915

17. I HEREBY CERTIFY That I attended deceased from

July 14, 1915, to July 15, 1915,

that I saw him alive on July 15, 1915,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. 6 mos. ds.

Contributory (SECONDARY)

Uremia

(Duration) yrs. mos. ds.

(Signed) M. B. Levene M. D.

July 15, 1915 (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 2 ds. In the 30 yrs. mos. ds.

Where was disease contracted, If not at place of death? at home

Former or usual residence 111 N. Front St

19-PLACE OF BURIAL OR REMOVAL

Hebrew Washington

DATE OF BURIAL

7/18, 1915

20-UNDERTAKER

John Levene

ADDRESS

1414 E. Balt St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *860 St. Pratt* ST.; *18* WARD)

REGISTERED NO. C

2-FULL NAME *Laura V. Petrich*(Residence in Baltimore: No. *860 St. Pratt*St.; *Lifetime* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

April 19th, 1915
(Month) (Day) (Year)

7-AGE,

0 yrs. *2* mos. *25* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Baltimore Md*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country), *Baltimore Md*

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country), *Washington D.C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jennie V. Petrich*(Address) *860 St. Pratt St**JUL 16 1915*

Filed.....

191.....

HARRY C. ANDERSON

Baltimore Health Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 14th, 1915, to *July 14th, 1915*,that I saw him alive on *July 14th, 1915*,and that death occurred, on the date stated above, at *340* m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum
(Duration)..... yrs. mos. *2* ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *Harry C. Anderson* M. D.*7/14/15* (Address) *873 To Lombard St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,
COLLEGE OF P. & S.DATE OF BURIAL
JUL 16 1915

20-UNDERTAKER

Commodore Health.

ADDRESS

FOR ANATOMICAL PURPOSES.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *1637 Thomas Ave* ST. *15* WARD)

2-FULL NAME *Bridget Walsh*

(Residence in Baltimore: No. *1637 Thomas Ave* ST. *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and room No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*

4-COLOR OR RACE *White*

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) *Widowed*

6-DATE OF BIRTH

July (Month) *1* (Day) *1846* (Year)

7-AGE

68 yrs. *7* mos. *1* day, *7* hrs., *1* min. If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) *None*

9-BIRTHPLACE
(State or country)

Ireland

10-NAME OF FATHER

James J. Walsh

11-BIRTHPLACE OF FATHER
(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Mary Walsh

13-BIRTHPLACE OF MOTHER
(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) *1637 Thomas Ave*

15-

Filed

JUL 16 1915

HARRY C. ANDREWS,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July (Month) *15* (Day) *1915* (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 1, 1915, to *July 15*, 1915,

that I saw her alive on *July 15*, 1915,

and that death occurred, on the date stated above, at *9:30* a.m.

The CAUSE OF DEATH* was as follows:

old age

(Duration) yrs. mos. ds.
Contributory (SECONDARY) *Exhaustion*

(Signed) *H. Young Worthon* M. D.
July 15, 1915 [Address] *1618 Gough St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Calhoun Cemetery

7/17/15

20-UNDERTAKER

ADDRESS

E. J. Fitzgerald 2433 North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28

086720

1 PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 528 N. Steppen St., 7 WARD)

2-FULL NAME

Chas. M. Bregel

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No. 528 N. Steppen St., 27 yrs. 8 mos. 2 ds.)

St.; 27 yrs. 8 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE MARRIED Married (Write the word)

6-DATE OF BIRTH Nov 12 1887 (Month) (Day) (Year)

7-AGE 27 yrs. 8 mos. 2 ds. or min. 1 day, hrs. If LESS than

8-OCCUPATION (a) Trade, profession or particular kind of work Bartender (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto.

10-NAME OF FATHER William Bregel 11-BIRTHPLACE OF FATHER (State or country) Balto 12-MAIDEN NAME OF MOTHER Katherine Knorr 13-BIRTHPLACE OF MOTHER (State or country) Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Lola Bregel (Address) 528 N. Steppen St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 14 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1915, to July 14, 1915, that I saw him alive on July 14, 1915, and that death occurred, on the date stated above, at 11:15 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 5 mos. 14 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Geo. A. Vignani M. D.

July 15, 1915 [Address] 2525 E. Monument St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Baltimore Cemetery July 18, 1915

20-UNDERTAKER ADDRESS

W. J. Dennis & Carroll 608 N. Potomac St.

JUL 16 1915

HARRY O. ANDREWS REGISTRAR

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *1721 N. Calhoun*)

2 FULL NAME

(Residence in Baltimore: No. *1721 N. Calhoun St*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

ST. *64* WARD) *15* Sr.: *75* yrs. — mos. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed* (Write the word)

6 DATE OF BIRTH *July 1st*, 1840 (Month) (Day) (Year)

7 AGE *75* yrs. *15* mos. *15* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) *House Wife*

9 BIRTHPLACE (State or country) *Baltimore*

10 NAME OF FATHER *John H. Huser*

11 BIRTHPLACE OF FATHER (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Fannie Hessler*

13 BIRTHPLACE OF MOTHER (State or country) *Germany*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Fannie C. Sarbacher*

(Address) *1721 N. Calhoun St*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 15*, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 1*, 1915, to *July 15*, 1915, that I saw her alive on *July 15*, 1915, and that death occurred, on the date stated above, at *11:15 P. m.* The CAUSE OF DEATH* was as follows:

Rheumatism

(Duration) *20* yrs. — mos. — ds.

Contributory (SECONDARY) *Apoplexy* (Duration) yrs. — mos. — ds.

(Signed) *J. Thomas Nolan* M. D. *July 16*, 1915 (Address) *1103 N. Fulton St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *West Cathedral* DATE OF BURIAL *July 19*, 1915

20 UNDERTAKER *William Cook* ADDRESS *502 E. North Ave*

JUL 16 1915

HARRY O. ANDREWS,

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

86722		HEALTH DEPARTMENT—CITY OF BALTIMORE		28		86722	
PLACE OF DEATH				CERTIFICATE OF DEATH.			
CITY OF BALTIMORE (No. <i>University Hospital</i> St. <i>22</i> WARD)		REGISTERED No. C		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)			
FULL NAME <i>Webster Johnson</i>		St.; yrs., <i>8</i> mo. <i>8</i> da.)					
(Residence in Baltimore: No. <i>810 S. Eutaw St.</i>							
PERSONAL AND STATISTICAL PARTICULARS.							
3-SEX. <i>male</i>	4-COLOR OR RACE. <i>Colored</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Single</i>					
6-DATE OF BIRTH. <i>Nov. 1894</i>							
7-AGE. <i>23</i> yrs. <i>8</i> mos. <i>8</i> da.		If LESS than 1 day, ... hrs. or ... min.?					
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Janitor (in a hotel)</i> (b) General nature of industry, business, or establishment in which employed (or employer).							
9-BIRTHPLACE. (State or Country), <i>Maryland</i>							
10-NAME OF FATHER, <i>Wm. A. Johnson</i>							
11-BIRTHPLACE OF FATHER (State or Country), <i>Md.</i>							
12-MAIDEN NAME OF MOTHER, <i>Hannah Johnson</i>							
13-BIRTHPLACE OF MOTHER (State or Country), <i>Md.</i>							
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Camelino Johnson</i> (Address) <i>510 W. W. St.</i>							
15- JUL 16 1915 HARRY O. ANDERSON Registrar.							
CORONER'S CERTIFICATE OF DEATH.							
16-DATE OF DEATH. <i>July 15, 1915</i>							
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>inquest</i> thereon and from the evidence obtained by said <i>inquest</i> and that said deceased came to <i>his</i> death on the day stated above. The CAUSE OF DEATH* was as follows: <i>Pulmonary tuberculosis</i> (Duration) <i>3</i> yrs. <i>2</i> mos. <i>8</i> da. CONTRIBUTORY (Secondary) <i>Pulmonary tuberculosis</i> (Duration) <i>3</i> yrs. <i>2</i> mos. <i>8</i> da. (Signed) <i>Moses M. Savage, M. D.</i> <i>July 16, 1915</i> (Address) <i>1724 Madison Ave.</i> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death <i>810 S. Eutaw St.</i> In the State <i>810 S. Eutaw St.</i> Where was disease contracted, if not at place of death? <i>Eutaw & Perry St.</i> Former or usual residence <i>810 S. Eutaw St.</i> 19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ADDRESS <i>St. Johns - Calvert Co Md. July 17 1915</i> UNDERTAKER <i>Wm. Cook</i> <i>502 E North</i>							

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *116* ST.: *18* WARD)

2-FULL NAME

(Residence in Baltimore: No. *116* St.: *18* yrs. *1* mos. *15* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

6-DATE OF BIRTH.

7-AGE.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUL 16 1915

191

HARRY O. ANDERSON

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

June 10, 1915, to July 15, 1915,

that I saw him alive on July 15, 1915,

and that death occurred, on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Provisional

Provisional

Provisional

Provisional

Provisional

Provisional

Provisional

Provisional

Provisional

Provisional

Provisional

Provisional

Provisional

Provisional

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Provisional

Provisional

Provisional

Provisional

Provisional

Provisional

Provisional

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country),10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

and that death occurred, on the date stated above, at 2:45 a.m.

The CAUSE OF DEATH* was as follows:

Emphysema of Gall Bladder

CONTRIBUTORY
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the 30 yrs.....mos.....ds. State

Where was disease contracted, if not at place of death? 516 W. Saratoga St

Former or usual residence 516 W. Saratoga St

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 Gountin ST.; 2 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2026 Gountin St.; 29 yrs., — mos., — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

Widow
(Write the word.)

6-DATE OF BIRTH

Month Know, 1846
(Month) (Day) (Year)

7-AGE

69 About
yrs. mos. ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Housewife
At Home9-BIRTHPLACE,
(State or Country),Germany

10-NAME OF FATHER

Joseph Mitowski11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Not Known13-BIRTHPLACE OF MOTHER
(State or Country),Not Known14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Kluszczyński
(Address) 435 S. Chestnut St.JUL 18 1915
Filed..... 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 24 1915, to July 14 1915, that I saw him alive on July 14 1915, and that death occurred, on the date stated above, at 7 P. m. The CAUSE OF DEATH* was as follows:Chronic Endocarditis(Duration) 27 yrs. — mos. — ds.CONTRIBUTORY
(Secondary)Pulmonary Congestion(Duration) 1 yrs. — mos. — ds.(Signed) J. M. Delaney M. D.
July 15, 1915. (Address) 621 Columbia St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary

DATE OF BURIAL

July 17, 1915

20-UNDERTAKER

William Haeberle

ADDRESS

16 Barstern

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Somerset ST.; 10 WARD)REGISTERED No. C 867262-FULL NAME John Timothy Mearns

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1103 Somerset St.; 2 yrs., 6 mos., 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, Dec 28, 1917
(Month) (Day) (Year)7-AGE, 7 yrs., 6 mos., 17 ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, Charles J. Mearns11-BIRTHPLACE OF FATHER (State or Country), Ireland12-MAIDEN NAME OF MOTHER Catherine Murphy13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Mearns(Address) 1103 Somerset St.

15-

JUL 16 1915 HARRY O. ANDREWS
JUL 16 1915 191... Harry O. Andrews
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 15, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 29 1915, to July 15 1915, that I saw him alive on July 15 1915, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Enteric colitis(Duration) yrs. mos. ds. 3 ds.CONTRIBUTORY (Secondary) Exhaustion(Duration) yrs. mos. ds. 3 ds.(Signed) Belmar Oliver M. D.1716, 1915 (Address) 914 E. Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New CatharinesDATE OF BURIAL, 7/17, 191520-UNDERTAKER Henry HorneADDRESS 13018 E. Ave. 1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

86728

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 4110 Fern Hill Av

WARD 15

2-FULL NAME

Clara Belle Fowler

(Residence in Baltimore: No. 4110 Fern Hill Av

Str. 58 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6-DATE OF BIRTH Dec 7, 1856 (Month) (Day) (Year)

7-AGE 58 yrs. 7 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) House Wife

9-BIRTHPLACE (State or country) Baltimore Md

10-NAME OF FATHER Isaac Brown

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Gossnell

13-BIRTHPLACE OF MOTHER (State or country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph A Fowler

(Address) 4110 Fern Hill Av

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH July 16, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1915, to July 16, 1915.

that I saw her alive on July 15, 1915, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

Contributory (SECONDARY) Valvular Heart Deficiency (Duration) alt 9 yrs. mos. ds.

(Signed) J. M. Stephen M. D. July 16, 1915 (Address) per J. S. H. Peter M. D. 608 E. Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Laurel July 18, 1915 Geo W Little 531 N Fremont

17 JUL 17 1915

OSBERT KRAUTER,

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N. Arlington Av. ST.; 16 WARD)

REGISTERED NO. C.

2-FULL NAME

(Residence in Baltimore: No.

Margaret Ellen German811 N. Arlington Av.St.; 47 yrs., — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow6-DATE OF BIRTH, July 8, 1844
(Month) (Day) (Year)7-AGE, 71 yrs., 0 mos., 8 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none9-BIRTHPLACE, (State or Country), West Virginia10-NAME OF FATHER, Michael Poisal11-BIRTHPLACE OF FATHER (State or Country), West Virginia12-MAIDEN NAME OF MOTHER Elizabeth Watts13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Bessie G. German(Address) 811 N. Arlington Av.15-
JUL 17 1915

Filed

JUL 17 1915

JUL 17 1915

JUL 17 1915

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 16, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1914, to July 16 1915, that I saw her alive on July 16 1915, and that death occurred, on the date stated above, at 12:40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(Duration) 1 yrs., — mos., — ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs., — mos., — ds.

(Signed) J. S. Jones M. D.July 16, 1915. (Address) 9235th St. Hyattsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mt. Olivet CemeteryJuly 19, 1915

20-UNDERTAKER

ADDRESS

Shaw-Women Co.108-W North Av.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

L. Bates Etchison
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2516 Guilford St., TV WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2516 Guilford St.; 41 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-~~STATUS~~ MARRIED,

Married
(Write the word.)

6-DATE OF BIRTH,

Sept. 12, 1864
(Month) (Day) (Year)

7-AGE,

61 yrs., 5 mos., 3 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

G. S. Etchison

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Rachel Brown

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Mrs. L. Bates Etchison
(Informant).....

(Address) 2516 Guilford

15-

JUL 17 1915

Filed.....

REGISTRY . ENACTED

HOSPITAL DEPT. OF HEALTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 15 1915, to July 15 1915,

that I saw him alive on July 15 1915,

and that death occurred, on the date stated above, at 4:15 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(Duration) 10 yrs., 4 mos., 9 ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis

(Duration)..... yrs., 6 mos.,..... ds.

(Signed) R. A. Harns M. D.

7/16 1915 (Address) 1625 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs.,..... mos.,..... ds. In the State..... yrs.,..... mos.,..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Burien Park

DATE OF BURIAL,

July 17, 1915.

ADDRESS

1003 N. Baltimore

20-UNDERTAKER

John D. Cook

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2142 Bayd*)ST.: *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2142 Bayd*)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country),

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- JUL 17 1915

ROBERT KRAUTER

Filed..... 191

Capital Permit Office

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

July 15 1915, to July 16 1915, that I saw her alive on July 15 1915, and that death occurred, on the date stated above, at 12:50 p.m.

The CAUSE OF DEATH was as follows:

Estrus & Enteric & Cholera (Illustrated)

CONTRIBUTORY (Secondary)

(Signed)

July 16 1915

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86732

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1207 Mullekun* ST. *5* WARD)

2-FULL NAME *Eleanora Miller*

(Residence in Baltimore: No. *1207 Mullekun* St. *31* yrs. *3* mos. *26* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Cool* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

6-DATE OF BIRTH

Mar 17, 1884
(Month) (Day) (Year)

7-AGE

31 yrs. *3* mos. *26* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work *Housework at home*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Balto Md

PARENTS

10-NAME OF FATHER

John H. Miller

11-BIRTHPLACE OF FATHER (State or country)

Md.

12-MAIDEN NAME OF MOTHER

Elyza A. Brown

13-BIRTHPLACE OF MOTHER (State or country)

Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elyza A. Miller
150 East St
(Address)

15-JUL 17 1915

HARRY O. ANDERSON

Barial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 13, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 9, 1915, to *July 13, 1915*

that I saw him alive on *July 13, 1915*

and that death occurred, on the date stated above, at *10 P* m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. *5* ds.

Contributory (SECONDARY)

Heartitis

(Duration) yrs. mos. *5* ds.

(Signed)

Robert A. Elliott M. D.
July 14, 1915 (Address) *1315 17th St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laurel Cemetery

July 17, 1915

Robert A. Elliott

504e Rodgers St

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

086733

086733

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 39 yrs. 1 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

1 COLOR OR RACE

B SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

4 DATE OF BIRTH

7 AGE

If LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

JUL 17 1915

HARRY O. ANDERSON,

Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

July 4, 1915, to July 16, 1915.

that I saw him alive on July 16, 1915.

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) yrs. 4 mos. ds.

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) J. J. McLean, M.D.

July 16, 1915 (Address) 1303 W. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

West Auburn

July 18, 1915

20 UNDERTAKER

ADDRESS

James H. Davis

1303 Buxton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1b.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female Colored* 4-COLOR OR RACE *Widow*

6-DATE OF BIRTH *Dec 14, 1859*

7-AGE *55* yrs. *7* mos. *3* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION *Housework*

9-BIRTHPLACE (State or country) *Md.*

10-NAME OF FATHER *Jas. Bowser*

11-BIRTHPLACE OF FATHER (State or country) *Md.*

12-MAIDEN NAME OF MOTHER *Lizzie Satter*

13-BIRTHPLACE OF MOTHER (State or country) *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Charlotte Cole*

(Address) *607 Greenwillow*

JUL 17 1915

HARRY O. ANDREWS,
Serial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 15, 1915*

17- I HEREBY CERTIFY. That I attended deceased from *3 July*, 1915, to *July 15*, 1915, that I saw her alive on *July 14*, 1915, and that death occurred, on the date stated above, at *2:30 P. m.* The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. *2* ds.

Contributory (SECONDARY) *arterio-sclerosis*

(Duration) yrs. mos. ds.

(Signed) *Frank C. Wagner* M. D.
July 15, 1915 (Address) *1006 Edmund*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Auburn

July 17, 1915

20-UNDERTAKER

ADDRESS

James H. Davis

1233 Chestnut

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *106 N. Vincent* ST.; *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *106 N. Vincent* St. *50* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *Caucasian* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widow* (Write the word.)

6-DATE OF BIRTH,

Jun - 28, 1837
(Month) (Day) (Year)

7-AGE

78 - 16
yrs. — mos. — ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *not any*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),*VA*

10-NAME OF FATHER,

*Edw. Braxton*11-BIRTHPLACE OF FATHER
(State or Country),*VA*

12-MAIDEN NAME OF MOTHER

*not known*13-BIRTHPLACE OF MOTHER
(State or Country),*VA*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edw. Braxton Jr.*(Address) *106 N. Vincent*

JUL 17 1915

HARRY O. ANDREWS,

Filed..... 191. *Marial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Mar 20 1915, to July 14 1915*that I saw her alive on *July 11 1915*and that death occurred, on the date stated above, at *3:15 P.M.*

The CAUSE OF DEATH* was as follows:

Nephritis (Chronic)(Duration) *3 yrs. 24 mos. 24 ds.*CONTRIBUTORY
(Secondary)*Arterial Sclerosis*(Duration) *5 yrs. 3 mos. 24 ds.*(Signed) *J. O. Smith* M. D.*July 14 1915* (Address) *1313 W. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Auburn

DATE OF BURIAL,

July 17 1915

20-UNDERTAKER

W. H. Brown & Son

ADDRESS

306

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2301 N. Charles ST.; 12 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

2-FULL NAME

(Residence in Baltimore: No. 2301 N. Charles St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MarriedWidowedOr divorced

(Write the word.)

6-DATE OF BIRTH

October 28 — 1839
(Month) (Day) (Year)

7-AGE

75 yrs. 8 mos. 18 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edmund Foster(Address) 924 Equitable Bldg

15-

JUL 17 1915

Filed.....

191.....

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 16, 1916
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

November 1914, to July 16, 1915.that I saw h alive on July 16, 1915.and that death occurred, on the date stated above, at 4:00 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Chronic HypertensionParalysis

N. B.—Every item of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1311 Milers*)

2-FULL NAME

Bridget Rodgers(Residence in Baltimore: No. *1311 Phelps*)

REGISTERED NO. C

ST. *9* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *40* yrs., *—* mos., *—* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Widow*

6-DATE OF BIRTH,

not known

(Month)

(Day)

(Year)

7-AGE,

about 66

yrs.

mos.

da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Stewardess at home*9-BIRTHPLACE,
(State or Country),*Ireland*

10-NAME OF FATHER,

*not known*11-BIRTHPLACE OF FATHER
(State or Country),*not known*

12-MAIDEN NAME OF MOTHER

*not known*13-BIRTHPLACE OF MOTHER
(State or Country),*not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Catharine Hagerty

(Address)

1305 Valley

15-

JUL 17 1915.

Filed

191

HARRY O. ANDREWS,**Marital Permit Clerk**

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 16, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *May 29* 191*5*, to *July 16* 191*5*, that I saw her alive on *July 15* 191*5*, and that death occurred, on the date stated above, at *3 P.* m.

The CAUSE OF DEATH* was as follows:

Intestinal Insufficiency
(Duration) *7* yrs. *—* mos. *—* da.CONTRIBUTORY
(Secondary)*Asthma*
(Duration) *3* yrs. *—* mos. *—* da.
(Signed) *L. M. C. Parker* M. D.
July 17, 1915. (Address) *1051 E. Eager St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Joseph's Cemetery Texas Path

DATE OF BURIAL,

July 17, 1915

20-UNDERTAKER

Henry Horckel

ADDRESS

1301 E. Eager St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

C86738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

C86738

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 N. Barr St.; 22 WARD)

2-FULL NAME

(Residence in Baltimore: No. 619 N. Barr St.; 22 yrs. 16 mos. 16 hrs.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single
(Write the word.)

6-DATE OF BIRTH

July 15, 1915
(Month) (Day) (Year)

7-AGE

16 yrs. 16 mos. 16 hrs.

If LESS than 1 day,
16 hrs. or 16 min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or Country)

Balto. Md

10-NAME OF FATHER

William Hall

11-BIRTHPLACE OF FATHER (State or Country)

Balto

12-MAIDEN NAME OF MOTHER

May Schul

13-BIRTHPLACE OF MOTHER (State or Country)

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Hall

(Address) 619 N. Barr

15-

JUL 17 1915 HARRY O. ANDREWS,
Filed 1915 Serial Permit Glor
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1915, to July 16 1915, that I saw her alive on July 16 1915, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(about 6 mos)

(Duration) 16 yrs. 16 mos. 16 hrs.

CONTRIBUTORY (Secondary)

(Duration) 16 yrs. 16 mos. 16 hrs.

(Signed) J. M. Delevette M. D.

July 16, 1915 (Address) 621 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Olivet

July 17, 1915

20-UNDERTAKER

ADDRESS

Geo Leimbach & Co 607 N Pratt St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 619 N. Barr St.; 22 WARD) REGISTERED NO. C. 151
2-FULL NAME Infant Hall
(Residence in Baltimore: No. 619 N. Barr St.; yrs. mos. 1 day)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
(Write the word.)
6-DATE OF BIRTH, July 15, 1915
(Month) (Day) (Year)
7-AGE, 10 yrs. 0 mos. 0 ds. If LESS than 1 day, 10 hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balt Md.

10-NAME OF FATHER, William Hall
11-BIRTHPLACE OF FATHER (State or Country), Balt Md.
12-MAIDEN NAME OF MOTHER, May Schul
13-BIRTHPLACE OF MOTHER (State or Country), Balt Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Hall

(Address) 619 N. Barr

15- JUL 17 1915 HARRY O. ANDREWS, Registrar.
Filed 191 Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15, 1915, to July 16, 1915, that I saw him alive on July 15, 1915, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth
about 6 m.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) J. M. Delaney M. D.
July 16, 1915 (Address) 621 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Oliver Cemetery July 17, 1915

20-UNDERTAKER ADDRESS

Geo. Limbach 647 N. Pratt

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1003 S. Para* ST.; *21* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1003 S. Para*St. *50* yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Widowed

6-DATE OF BIRTH,

Feb 13, 1835
(Month) (Day) (Year)

7-AGE,

80 yrs. 5 mos. 2 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Shoe maker*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

*Wm Brandt*11-BIRTHPLACE OF FATHER
(State or Country)*Germany*

12-MAIDEN NAME OF MOTHER

*Not known*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Melf*(Address) *1003 S. Para*

15-

Filed

JUL 17 1915

191

HARRY O. ANDREWS,
Chief Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

July 1, 1914, to *July 15, 1915*,that I saw him alive on *July 15, 1915*,and that death occurred, on the date stated above, at *90* m.

The CAUSE OF DEATH* was as follows:

Spinal Paralysis(Duration) *1* yrs. *5* mos. *2* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. *5* mos. *2* ds.(Signed) *Wm Brandt* M. D.*July 16, 1915* (Address) *535 E. Pratt St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Schwartz Center July 18, 1915

20-UNDERTAKER

ADDRESS

Geo Limbaeda 6474 Pratt St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No.

2711 West-Lafayette ave. 16

WARD)

2-FULL NAME

Nicholas Perry Stinchcomb

(Residence in Baltimore: No.

2711 West-Lafayette ave. St.

— yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

July 15, 1915

(Month)

(Day)

(Year)

7-AGE

78

yrs.

7 mos.

ds.

or

min.?

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Miller

9-BIRTHPLACE

(State or country)

Maryland

10-NAME OF FATHER

Nelson Stinchcomb

11-BIRTHPLACE OF FATHER

Maryland

12-MAIDEN NAME OF MOTHER

E. Gush-

13-BIRTHPLACE OF MOTHER

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Byron Stinchcomb

(Address)

2711 W. Lafayette

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 16, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from May 15, 1915, to date of death,

that I saw him alive on July 15, 1915, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Death was the result of Myelitis of Spinal Cord

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

Thos. L. Davis

July 14, 1915

[Address] 827 N. Tenth

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

July 18, 1915

20-UNDERTAKER

W. H. McCormick 1931 W. Lafayette

ADDRESS

15 JUL 17 1915

Filed 191

Serial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 N. Caroline ST.; 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 22 N. Caroline St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Caucasian5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widowed
(Write the word.)

6-DATE OF BIRTH.

August 1
(Month) (Day) (Year)

7-AGE.

40If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Cook

(b) General nature of industry, business, or establishment in which employed (or employer).

Private Family9-BIRTHPLACE,
(State or Country).Somerset Co. Md

PARENTS.

10-NAME OF FATHER.

John Hardy11-BIRTHPLACE OF FATHER
(State or Country).Md.

12-MAIDEN NAME OF MOTHER

Winkler13-BIRTHPLACE OF MOTHER
(State or Country).Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hardy(Address) 22 N. Caroline St

15-

JUL 17 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 4, 1914, to July 15, 1915,that I saw him alive on July 12, 1915,and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 1 yrs., 3 mos., — ds.CONTRIBUTORY
(Secondary)(Duration) — yrs., — mos., — ds.(Signed) E. B. Minton, M. D.July 16, 1915 (Address) 1711 E. Bath St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Asbury Cemetery

DATE OF BURIAL,

July 18 1915

20-UNDERTAKER

R. B. Gross 1405 McElderry

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1222 S. Paca* ST.: *21* WARD)2-FULL NAME *William E. Stovall*(Residence in Baltimore: No. *1222 S. Paca* St. *Life* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

Jan. 19th, 1914
(Month) (Day) (Year)

7-AGE.

1 yr. 6 mos. 27 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Balto City Md.

10-NAME OF FATHER.

Edward Stovall

11-BIRTHPLACE OF FATHER (State or Country).

Georgia

12-MAIDEN NAME OF MOTHER

Elizabeth Doulton

13-BIRTHPLACE OF MOTHER (State or Country).

Balto City Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elizabeth Stovall*(Address) *1222 S. Paca St*

15-JUL 17 1915

Filed....., 191.....

HARRY O. ANDREWS,
Baltimore Health Officer
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 16, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *7-12-1915*, to *7-16-1915*, that I saw him alive on *7-16-1915*, and that death occurred, on the date stated above, at *2 P.M.*

The CAUSE OF DEATH* was as follows:

Ileo-colitis

(Duration).....yrs...1...mos...4...ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs...mos...ds.

(Signed) *M. B. Lichtenberg* M. D.*7-16-1915*, 1915. (Address) *1120 W. City St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1 yr. 6 mos. 27 ds.* In the State.....yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Cath Lane Cemetery July 18, 1915

20-UNDERTAKER

ADDRESS

Anderson Sons 1710 Blad St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86744

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *210 Calver*)
 2-FULL NAME *Albat Boston*
 (Residence in Baltimore: No. *210 Calver St.*)

St. *5* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *Colored* 5-SINGLE, *Single*
 6-DATE OF BIRTH, *June 10, 1877*
 7-AGE, *38* yrs. *1* mos. *5* ds. If LESS than 1 day, ... hrs. or ... min.
 8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Laborer*
 (b) General nature of industry, business, or establishment in which employed (or employer), *General*

9-BIRTHPLACE, (State or Country), *Maryland*
 10-NAME OF FATHER, *Steve Boston*
 11-BIRTHPLACE OF FATHER (State or Country), *Maryland*
 12-MAIDEN NAME OF MOTHER, *Anna Shaw*
 13-BIRTHPLACE OF MOTHER (State or Country), *Not*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *Genie Gross*
 (Address) *210 Calver St.*

15- *JUL 17 1915* HARRY O. ANDREWS, Registrar.
 Filed *Marial Permit. Olor's*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 15, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* thereon and from the evidence obtained by said *inquest* find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic endocarditis
Aortic regurgitation
 (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
 (Signed) *Thos. H. Chambers* M. D.
July 15, 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
 At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.
 Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Mount Zion Cemetery July 18, 1915*

20-UNDERTAKER ADDRESS *Milton Davis 1608 McEldery St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *205 Albemarle* ST.; *3rd* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Harry Cohen*(Residence in Baltimore: No. *205 Albemarle* St.; yrs. *1* mos. *8* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*6-DATE OF BIRTH, *Unknown*

(Month)

(Day)

(Year)

7-AGE, *8* yrs. *8* mos. *8* da.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore Md.*10-NAME OF FATHER, *Benjamin Cohen*11-BIRTHPLACE OF FATHER (State or Country), *Russia*12-MAIDEN NAME OF MOTHER *Annie Bernstein*13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Benjamin Cohen*(Address) *205 Albemarle St.*

15-

Filed *JUL 17 1915*

191

HARRY O. ANDERSON

Barral. Permit. Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 17th, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 16* 1915, to *July 17* 1915, that I saw him alive on *July 17* 1915, and that death occurred, on the date stated above, at *2 a.* m.

The CAUSE OF DEATH* was as follows:

Exhaustion.(Duration) yrs. *4* mos. *4* da.CONTRIBUTORY (Secondary) *Acute Gastro-Enteritis*(Duration) yrs. *7* mos. *7* da.(Signed) *A. Palmisano* M. D.*July 17, 1915* (Address) *316 S. Exeter St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Lehew Mt Carmel*DATE OF BURIAL, *July 17 1915*20-UNDERTAKER *J. Lerinson & Bro*ADDRESS *1107 E*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 E. Preston ST. 11 WARD)

REGISTERED NO. C

2-FULL NAME

Maria Prestman Heyward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

(Residence in Baltimore: No. 112 E. Preston St.St.: 40 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Widow

6-DATE OF BIRTH.

January 29, 1828
(Month) (Day) (Year)

7-AGE.

87 yrs., 6 mos., 17 da.If LESS than 1 day,
....hrs. ormin.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Lady9-BIRTHPLACE,
(State or Country).Wilmington Del

10-NAME OF FATHER.

Rev. Steven Wilson Prestman11-BIRTHPLACE OF FATHER
(State or Country).Charleston S.C

12-MAIDEN NAME OF MOTHER

Anne Brundidge13-BIRTHPLACE OF MOTHER
(State or Country).Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. W. P. Heyward(Address) 112 E. Preston St.15-
JUL 17 1915HARRY O. ANDERSON
Serial Permit Clerk

Filed..... 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 17th, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 1914, to July 1915, that I saw her alive on July 16th, 1915, and that death occurred, on the date stated above, at 8 A. m.
The CAUSE OF DEATH* was as follows:Small suppurative embolism
(Duration) 4 yrs., 4 mos., da.CONTRIBUTORY
(Secondary)Paralysis following stroke
(Duration) 4 yrs., 4 mos., da.
(Signed) Jas. H. Crangh M. D.
July 17, 1915 (Address) 1800 E. St. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Wilmington Del.

DATE OF BURIAL.

July 19, 1915.

20-UNDERTAKER

Henry W. Fether

ADDRESS

Wilmington Del.WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1137 Hancock* ST. *23* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME. Instead of street and number and fill out No. 18.)

2-FULL NAME *August Kerp*(Residence in Baltimore: No. *1137 Hancock* St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)6-DATE OF BIRTH, *Mar 23*, 18*44*

(Month)

(Day)

(Year)

7-AGE, *71* yrs., *3* mos., *22* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Carpenter*(b) General nature of industry, business, or establishment in which employed (or employer). *General*9-BIRTHPLACE, (State or Country), *Mad*10-NAME OF FATHER *Christopher Kerp*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Wittman*13-BIRTHPLACE OF MOTHER (State or Country), *German*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Kerp*(Address) *1137 Hancock St.*

15 JUL 17 1915

HARRY O. ANDREWS,

Filed....., 191... Serial Permit. Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 15*, 191*5*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *July* 191*4*, to *July 15* 191*5*, that I saw him alive on *July 15* 191*5*, and that death occurred, on the date stated above, at *11 A.m.*

The CAUSE OF DEATH* was as follows:

*Arterio Sclerosis*CONTRIBUTORY (Secondary) *Cerebral Hemorrhage*(Signed) *R. P. Campbell*

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park Cem.*DATE OF BURIAL, *July 18*, 191*5*20-UNDERTAKER *E. Schloman & Son*ADDRESS *1039*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86718

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86718

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 618 W Bame

ST.: 22

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

Myrtle Rummel

(Residence in Baltimore: No. 618 W Bame

St.: yrs., 9 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Oct

13, 1914

(Month)

(Day)

(Year)

7-AGE,

9 3

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Balto

10-NAME OF FATHER,

Henry Rummel

11-BIRTHPLACE OF FATHER

(State or Country),

Balto

12-MAIDEN NAME OF MOTHER

Etta Sweet

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Rummel

(Address)

618 W. Bame St

15-

FRI

JUL 17 1915

HARRY O. ANDREWS,

Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

16

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

(Signed)

July 17, 1915

(Address)

413 N. Carroll St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cella, Balto. Co, Md

July 18, 1915

20-UNDERTAKER

ADDRESS

Jas. Riquartson 1000 S. Yaca

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86749

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86749

CERTIFICATE OF DEATH.

28
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *8 S. Ellwood Ave* ST.: *1* WARD)

2-FULL NAME

(Residence in Baltimore: No. *8 S. Ellwood Ave* St.: *2* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Oct. 19, 1898
(Month) (Day) (Year)

7-AGE,

16 yrs. 8 mos. 29 ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Labour in factory

9-BIRTHPLACE,

(State or Country),

Cambridge Ind.

10-NAME OF FATHER,

Frank Slacum

11-BIRTHPLACE OF FATHER (State or Country),

Ind.

12-MAIDEN NAME OF MOTHER

Flourne Lewis

13-BIRTHPLACE OF MOTHER (State or Country),

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*Frank Slacum*(Address).....*8 S. Ellwood Ave*

15-JUL 17 1915.

HARRY O. ANDREWS,

Filed....., 191.....*Barial Parmita Gler*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 16, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *July 16, 1915*, to *July 16, 1915*, that I saw him alive on *July 16, 1915*, and that death occurred, on the date stated above, at *3:30 a.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

CONTRIBUTORY (Secondary)

Pulmonary Tuberculosis
(Duration)..... yrs. mos. ds.
(Signed).....*H. C. Meier*..... M. D.
July 17, 1915 (Address).....*303 E. Balt.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cambridge Ind. *Aug 17, 1915*

20-UNDERTAKER

ADDRESS

John A. Moran Bank & Co.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; WARD)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C.

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country).

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-I HEREBY CERTIFY, That I attended deceased from

July 16, 1915, to July 16, 1915,

that I saw her alive on July 16, 1915,

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Gastric Ectentis
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)(Signed).....M. D.
7/16, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. Is the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Western Cemetery

July 18, 1915

20-UNDERTAKER

ADDRESS

George J. Smith

1030 N. ...

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15-

Filed

JUL 17 1915

HARRY O. ANDREWS,

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

894 Boyd

2-FULL NAME

John M Taylor

(Residence in Baltimore: No.

894 Boyd

REGISTERED NO. C

ST.; 18 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 42 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE,

colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married.

6-DATE OF BIRTH,

unknown, 1873
(Month) (Day) (Year)

7-AGE,

42 yrs. 3 mos. 3 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

general laborer

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

John Taylor

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland.

12-MAIDEN NAME OF MOTHER

Mary Jane Fountain

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).... Chester Poland, Md.

(Address).... 2532 Edmondson Ave.

15-

JUL 17 1915

HARRY O. ANDREWS

Filed

191

Porter-Pearl-Glor

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 6, 1915, to July 16, 1915,

that I saw him alive on July 14, 1915,

and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Acute pneumonic phthisis

(Duration).... yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration).... yrs. mos. ds.

(Signed).... Chester Poland, M. D.

July 16, 1915. (Address).... 2532 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Lynch Cemetery July 18, 1915.

20-UNDERTAKER

ADDRESS

John Cowan 905 Hollins

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Sallie C. Johnson*(Residence in Baltimore: No. *Baldwin*, *md* St. *—* yrs. *—* mos. *—* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*4-COLOR OR RACE. *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Unknown, 1857*

(Month)

(Day)

(Year)

7-AGE, *58*yrs. *—* mos. *—* da.If LESS than 1 day, *—* hrs. or *—* min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *HW*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *md.*

PARENTS.

10-NAME OF FATHER, *Elijah Moore*11-BIRTHPLACE OF FATHER (State or Country), *md*12-MAIDEN NAME OF MOTHER *Louise Coale*13-BIRTHPLACE OF MOTHER (State or Country), *md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Clara Babelik*(Address) *Laura Md*

15-

FILED

JUL 17 1915

HARRY O. ARNOLD,

1915 *Marital Permit* *Clara* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 17, 1915*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 18* 1915, to *July 17* 1915, that I saw her alive on *July 16* 1915, and that death occurred, on the date stated above, at *5:30* m.

The CAUSE OF DEATH* was as follows:

Operation on lungs
Carcinoma of Puerperal
with cholecyctitis
(Duration) *Unknown*CONTRIBUTORY *Broncho Pneumonia*
(Secondary)(Duration) *10* yrs. *—* mos. *—* da.(Signed) *W. H. Johnston* M. D.*July 17, 1915* (Address) *University Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *—* mos. *—* da. In the *58* yrs. *—* mos. *—* da. State *—* yrs. *—* mos. *—* da.Where was disease contracted, if not at place of death? *Unknown*Former or usual residence *Hyde, md*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fort. Mc. Cemetery *July 19, 1915*

20-UNDERTAKER

ADDRESS

John Auther & Son *Fort. Md.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86753

PLACE OF DEATH

64
REGISTERED NO. C

CITY OF BALTIMORE (No. 2316

ST.

WARD) 12

FULL NAME

(Residence in Baltimore: No. 2316

St.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. MARRIAGE

WIDOWED

(Write the word)

6. DATE OF BIRTH

7. AGE

If LESS than

1 day, hrs.

or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

JUL 17 1915

Filed

HARRY O. ANDREWS,

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 9:45 am.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2609 W Fayette St.* ST.; *30* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2609 W Fayette St.* St.; *788* yrs. *10* mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Single*

6-DATE OF BIRTH,

*July**17**1915*

(Month)

(Day)

(Year)

7-AGE,

*788**10* yrs. *10* mos. *10* ds.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, business, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Md*

10-NAME OF FATHER,

B. H. Gerlach

11-BIRTHPLACE OF FATHER

(State or Country), *Md*

12-MAIDEN NAME OF MOTHER

Annie F. Lind

13-BIRTHPLACE OF MOTHER

(State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *B. H. Gerlach*(Address) *2609 W. Fayette St.*

15-

JUL 18 1915

HARRY O. ANDERSON,

Filed....., 191.....

Marial Permit. Olay

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**17**1915*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *July 17 1915* to *July 17 1915*, that I saw him alive on *July 17 1915*, and that death occurred, on the date stated above, at *2:30 P.M.*

The CAUSE OF DEATH* was as follows:

Fall of mother

(Duration)..... yrs. mos. ds.

CONTRIBUTORY.

(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *Howard Kahan* M. D.*July 17 1915* (Address) *5077 W. Fayette St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Lincoln Park Cem**July 18, 1915*

20-UNDERTAKER

ADDRESS

*for funeral services**217 S. Race*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

108

St.;yr.,mos.da.)

Las Lascas Jan 217 J. P. W.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86756

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.; *W.H.* WARD)

REGISTERED No. C

2-FULL NAME

Rolie Broom

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *113 Harrison St. Balto., Md.* St.; *10* yrs., *10* mos., *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

September

(Month)

(Day)

1914

(Year)

7-AGE,

10 yrs., *10* mos., *10* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Herbert Broom

11-BIRTHPLACE OF FATHER (State or Country),

Balto., Md.

12-MAIDEN NAME OF MOTHER

Annie Paul

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. Knepper*(Address) *Johns Hopkins Hosp.*

15-

JUL 18 1915

HARRY O. ANDREWS,

Filed..... 191... *Marial Permit Oler*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

(Month)

(Day)

16, *1915*

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 13 191*5*, to *July 16*, 191*5*that I saw h. *er* alive on *July 16*, 191*5*and that death occurred, on the date stated above, at *6:50 PM*

The CAUSE OF DEATH* was as follows:

Alimentary Intoxication(Duration).....yrs.....mos.....*7* ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Alma S. Roberts* M. D.*July 16*, 191*5*. (Address) *Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....*3* ds. In the *10* yrs., *10* mos., *10* ds.Where was disease contracted, if not at place of death? *113 Harrison St*Former or usual residence *113 Harrison St. Balto.*

19-PLACE OF BURIAL OR REMOVAL,

Men Cathedral

DATE OF BURIAL,

7...*18*... 191*5*

20-UNDERTAKER

Wm. M. Ganthrop

ADDRESS

*1624 H. Mt**Prayer Ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86757

HEALTH DEPARTMENT—CITY OF BALTIMORE.

C86757

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *135 North Broadway*)

2 FULL NAME *Thomas E. Mason*

(Residence in Baltimore: No. *Lifeline*)

REGISTERED NO. C *120*

ST. *6* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

ST. *Lifeline* MON. *Lifeline* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word)

6 DATE OF BIRTH *Dec 10th*, 18*52*
(Month) (Day) (Year)

7 AGE *62* yrs. *7* mos. *7* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Real Estate Dealer*
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Baltimore Md.*

10 NAME OF FATHER *Thos. Mason*

11 BIRTHPLACE OF FATHER (State or country) *Balto. Md.*

12 MAIDEN NAME OF MOTHER *Mary Cecil*

13 BIRTHPLACE OF MOTHER (State or country) *Balto. Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Mary Bonnell*
(Address) *135 North Broadway*

JUL 18 1915

Filed 191

HARRY C. ANDREWS,
Marial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH *July 17th*, 191*5*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Nov-*, 191*4*, to, *July 17th*, 191*5*, that I saw him alive on *July 17th*, 191*5*, and that death occurred, on the date stated above, at *7:15 a.m.*
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Contributory (SECONDARY) *Uremia - Coma*
(Duration) yrs. *9* mos. *-* ds.

(Signed) *Thos. E. Mason* M. D.
July 17, 191*5* (Address) *125 North Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Green Mount*

DATE OF BURIAL *July 20*, 191*5*

20 UNDERTAKER *Scott M. Gray*

ADDRESS *135 North Broadway*

C86759

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.

1008 E. Lombard

ST.; 3 WARD)

2-FULL NAME

Samuel Nelson

(Residence in Baltimore; No.

1008 E. Lombard

St.; 20 yrs., mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

Married

(Write the word.)

6-DATE OF BIRTH

July

(Month)

(Day)

1845

(Year)

7-AGE

70 yrs. — mos. — da.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Tailor
mens9-BIRTHPLACE,
(State or Country),

Russia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

J. Lewis

(Address).....

1419 E. Baltimore

JUL 18 1915

HARRY O. ANDERSON

Filed.....

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 17

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 15th 1915, to July 17 1915,

that I saw him alive on July 17 1915,

and that death occurred, on the date stated above, at 12³⁰ m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of
the liver

(Duration) 3 yrs. — mos. — da.

CONTRIBUTORY
(Secondary)

alcoholic

(Signed) J. Palmer M. D.

July 18, 1915. (Address) 316 S. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Cemetery

DATE OF BURIAL,

July 18, 1915.

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86760

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86760

CERTIFICATE OF DEATH.

x 37

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.

Johns Hopkins Hosp St. 7

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Jefferson Bookman
Fort Pottersdale Fla

(Residence in Baltimore; No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

Colored

5-SINGLE,
MARRIED, Single
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

August 15, 1865
(Month) (Day) (Year)

7-AGE.

49 yrs. 11 mos. ds.

If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work. Farmer
(b) General nature of industry, business, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country),

I. C.

10-NAME OF
FATHER,

Lazare Bookman

11-BIRTHPLACE
OF FATHER
(State or Country),

I. C.

12-MAIDEN NAME
OF MOTHER

Sylvia Taylor

13-BIRTHPLACE
OF MOTHER
(State or Country),

I. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

A. J. Smith

(Address)

Johns Hopkins Hosp

15-

JUL 18 1915 HARRY O. ANDREWS,
Filer Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1, 1915, to July 15, 1915,
that I saw him alive on July 14, 1915,
and that death occurred, on the date stated above, at 10:40 a.m.

The CAUSE OF DEATH* was as follows:

Epilepsy (Grand mal)
Coronary atherosclerosis

(Duration) yrs. 15 mos. ds.

CONTRIBUTORY

(Signed) Edward B. B. M. D.
July 15, 1915. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 15 mos. ds. In the State yrs. 1 mos. 1 ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

Fort Pottersdale Fla

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Fort Lauderdale Fla 7.18, 1915.

20-UNDERTAKER

ADDRESS

John H. Owens 1222 Division

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *216 N. Amity*) ST.: *18* WARD)
2-FULL NAME *Emma Young*
(Residence in Baltimore: No. *216 N. Amity St.*) St.; yrs., *67* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Female</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>Widow</i> (Write the word.)
6-DATE OF BIRTH, <i>February 2, 1848</i> (Month) (Day) (Year)		
7-AGE, <i>67</i> yrs. <i>5</i> mos. <i>13</i> ds. If LESS than 1 day, ... hrs. or ... min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>none</i> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), <i>Balt. Md.</i>		
PARENTS.	10-NAME OF FATHER, <i>Vinyard</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Md.</i>	
	12-MAIDEN NAME OF MOTHER <i>unknown</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Md.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Mrs. Katharine L. Lacey*
(Address) *216 N. Amity*

15-*JUL 18 1915* HARRY O. ANDREWS,
Filed....., 191*5* JUL *18* 191*5*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 15, 1915*
(Month) (Day) (Year)
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquiry* (Inquest, autopsy or inquiry.) find that said deceased came to *her* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Apoplexy,
(Duration)..... yrs..... mos..... ds.
CONTRIBUTORY (Secondary) *Chronic Hemiplegia*
(Duration)..... yrs..... mos..... ds.
(Signed) *Moses M. Savage* M. D.
(Coroner.)
July 17, 1915 (Address) *1729 Madison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,
London Park July 19, 1915
20-UNDERTAKER, ADDRESS *John A. Moran*
Bank

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *924 Harris Alley*)

2-FULL NAME

John C. Dorn

(Residence in Baltimore: No. *924 Harris Alley*)

St.:

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Jan

7th

1906

(Month)

(Day)

(Year)

7-AGE,

9

yrs.

6

mos.

10

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

School boy

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

John W. Dorn

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Annie Kelly

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

John W. Dorn

(Address).....

924 Harris Alley

15-

JUL 18 1915

HARRY O. ANDREWS

FILED

101

SPECIAL PERMIT CLERK

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

17th

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-

..... find that said deceased came to..... death

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... *David W. Jones* M. D. (Coroner.)

July 17th 1915 (Address)..... *3116 O'Connell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Schwartz Cem

7/18, 1915

20-UNDERTAKER

ADDRESS

William Cook

502 E. North

C86763

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86763

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1)

2-FULL NAME

(Residence in Baltimore: No. 1614)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 7 yrs., 5 mos 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

101

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
(Fort of Hull St.)
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. J. Cromple M. D.
(Coroner.)

July 18, 1915. (Address) 5117 Lehigh

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *652 Butman Ave* ST. *9* WARD)

2-FULL NAME

Elizabeth J. Mac Clelland

(Residence in Baltimore: No. *652 Butman Ave*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

Nov 29th, 1859
(Month) (Day) (Year)

7-AGE,

55 yrs. *7* mos. *17* ds.

If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE, (State or Country),

md.

PARENTS.

10-NAME OF FATHER,

Matthias Zink

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Elizabeth Sonnenfeldt

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Matthias Zink*

(Address) *652 Butman Ave*

15-

JUL 18 1915

Filed *101*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 17th, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*
(Inquest, autopsy or inquiry.)

and that said deceased came to *death*
on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Edgar Russell* M. D.
(Coroner.)

July 18, 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Levin Ridge

DATE OF BURIAL,

July 20 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E. 10th

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1600 W. Lanvale

ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Dora Barrett

(Residence in Baltimore: No.

1600 W. Lanvale

St.; 25 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

widow

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

42

yrs., mos., ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Va

10-NAME OF FATHER,

James W. Vaughan

11-BIRTHPLACE OF FATHER

(State or Country),

Va

12-MAIDEN NAME OF MOTHER

Mary E. Goodall

13-BIRTHPLACE OF MOTHER

(State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mabel M. Barrett

(Address)

1600 W. Lanvale St

15-

JUL 18 1915

HARRY O. ANDREWS

Filed

JUL 17 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 19

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 12 1913, to July 16, 1915,

that I saw him alive on 191

and that death occurred, on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH* was as follows:

Causes of N. Fract.

Exhaustion

CONTRIBUTORY (Secondary)

(Duration) 3 yrs., mos., ds.

(Signed) J. W. Chambers M. D.

July 17, 1915 (Address) 18 N. Franklin St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Richmond Va

20-UNDERTAKER

William Cook 502 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hosp* ST. *11* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Ellicott City* Ind St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH

Unknown to her 1 (Month) (Day) (Year)

7-AGE

84 yrs. *?* mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Retired House Wife*(b) General nature of industry, business, or establishment in which employed (or employer) *Farm*

9-BIRTHPLACE

(State or Country) *Maryland*

10-NAME OF FATHER

Edward Williams

11-BIRTHPLACE OF FATHER

(State or Country) *not known*

12-MAIDEN NAME OF MOTHER

Elizabeth Shaw

13-BIRTHPLACE OF MOTHER

(State or Country) *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert C. Johnson*(Address) *Ellicott City*

15- JUL 18 1915

Filed..... 191.....

Registrar. *H. Sullenger*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 18, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 12 1915, to *July 18* 1915,that I saw her alive on *July 17* 1915,and that death occurred, on the date stated above, at *4:25* a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (following Old Chronic Bronchitis)(Duration) yrs. mos. ds. *2*

CONTRIBUTORY (Secondary)

fracture neck right femur(Duration) yrs. mos. ds. *6*(Signed) *William B. Blanchard* M. D.*July 18*, 1915. (Address) *Ind Gen Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. *6* In the *84* yrs. mos. ds.Where was disease contracted, if not at place of death? *Ellicott City Ind*Former or usual residence *Ellicott City Ind*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL

St Johns Cemetery *July 20*, 1915UNDERTAKER *Ellicott City Ind* ADDRESS*H. Sullenger* *Ellicott City*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

86767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

56

86767

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

347 N. Calvert

ST. 11

WARD)

REGISTERED NO. C

2-FULL NAME

Lawrence Donnelly

(Residence in Baltimore: No.

347 N. Calvert St.

St.; yrs., mos. 12 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male.

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Single

6-DATE OF BIRTH.

Unknown

(Month)

(Day)

(Year)

7-AGE.

about 66

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Gardener

9-BIRTHPLACE.

(State or Country),

Ireland.

10-NAME OF FATHER.

Not known

11-BIRTHPLACE OF FATHER.

(State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Harry O. Callahan

(Address)...

347 N. Calvert St.

15-JUL 18 1915

HARRY O. ANDREWS,

Filed....., 191..

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July

17, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

And that said deceased came to death on the day stated above.

THE CAUSE OF DEATH was as follows:

as: cardiac dilatation

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

(Coroner).....

July 17, 1915 (Address).....

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

St. Marys Cem. Greenstone

DATE OF BURIAL,

July 18, 1915

20-UNDERTAKER

G. Fink & Son

ADDRESS

715 N. Gay St.

C86768

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86768

CERTIFICATE OF DEATH.

30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1908 Patterson Place* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1908 Patterson Place* St.: *1* yrs., *4* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE

White

5-SINGLE,

Single
MARRIED,
WIDOWER,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

March 17

(Month)

(Day)

1914
(Year)

7-AGE,

1 yrs., *4* mos., *—* ds.

If LESS than 1 day,

...hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JUL 18 1915 HARRY O. ANDREWS,

Filed..... 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 17

(Month)

(Day)

1915
(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 16 1915, to *July 17* 1915,that I saw her alive on *July 17* 1915,and that death occurred, on the date stated above, at *50* m.

The CAUSE OF DEATH* was as follows:

T.B. Meningitis

.....

..... (Duration)..... yrs..... mos. *4* ds.CONTRIBUTORY.....
(Secondary)..... (Duration)..... yrs..... mos. *14* ds.

(Signed)..... M. D.

July 17, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Baltimore

20-UNDERAKER.....

Robt. S. Turner

DATE OF BURIAL,

July 18, 1915

ADDRESS

1442 N. Park

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113

C86769

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

Str.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than 1 day, — hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

JUL 18 1915

HARRY O. ANDREWS,
Marial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:

(Duration) — yrs. — mos. — ds.

Contributory (SECONDARY)

(Signed) Frank E. Wagner, M. D.
July 19, 1915 (Address) 1006 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 Riverside Ave. ST. 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1026 Riverside Ave. St. 24 yrs. 15 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

March 25th, 1859
(Month) (Day) (Year)

7-AGE,

56 yrs. 3 mos. 20 ds.If LESS than 1 day,
...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Boiler Maker9-BIRTHPLACE,
(State or Country),Baltimore Md.

PARENTS.

10-NAME OF FATHER,

John Riley11-BIRTHPLACE OF FATHER
(State or Country),Baltimore Md.

12-MAIDEN NAME OF MOTHER

Not known.13-BIRTHPLACE OF MOTHER
(State or Country),Not known.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Riley(Address) 1026 Riverside Ave.

15-

JUL 18 1915 BARRY O. ANDERSON

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 13, 1915, to July 15, 1915, that I saw him alive on July 15, 1915, and that death occurred, on the date stated above, at 10:20 p.m.

The CAUSE OF DEATH* was as follows:

Natural Causes
Myocardial Infarction
(Duration) 1 yrs. 1 mos. 1 ds.CONTRIBUTORY
(Secondary)(Signed) Robert P. Schmidt M. D.
July 17, 1915. (Address) 1318 E. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Mount Olivet Cem. July 18, 1915

20-UNDERTAKER

E. B. Harle ADDRESS 115 E. Mead St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1129 Riverside Ave* St. *2nd* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1129 Riverside Ave* St. *70* yrs. *5* mos. *10* ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH

February 6th 1834
(Month) (Day) (Year)

7-AGE

81 yrs. 5 mos. 10 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*None*

9-BIRTHPLACE, (State or Country),

Germany.

10-NAME OF FATHER

Anton Grepp.

11-BIRTHPLACE OF FATHER (State or Country),

Germany.

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER (State or Country),

Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elizabeth Reith.*(Address) *Bloomberry Ave Catonsville*

15-

Filed...

JUL 18 1915

BARRY O. ANDREWS

Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 16th 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 17 1915, to *July 16 1915*that I saw him alive on *July 13 1915*and that death occurred, on the date stated above, at *2:30 P.* m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope.
(Duration) *...* yrs. *...* mos. *...* ds.

CONTRIBUTORY (Secondary)

Same as primary.
(Duration) *...* yrs. *...* mos. *...* ds.(Signed) *G. H. Smith* M. D.*July 17, 1915.* (Address) *905 N. E. Street*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *...* yrs. *...* mos. *...* ds. In the State *...* yrs. *...* mos. *...* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL

*Holy Cross A.C.C.**July 19th 1915*

20-UNDERTAKER

E. B. Harle

ADDRESS

115 E. West St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

C86772

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *703 S Charles* ST.; *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Harry Lichtenstein*(Residence in Baltimore: No. *703 S Charles*St.; *20* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-~~SEX~~ MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown, 1

(Month) (Day) (Year)

7-AGE,

49

yrs. — mos. — ds.

10 LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Merchant
Clothing

9-BIRTHPLACE,

(State or Country),

Russia

10-NAME OF FATHER,

Jacob Lichtenstein

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Lingal*(Address) *703 S Charles St*

15-

JUL 18 1915

Filed

191

Serial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 17, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 13, 1915*, to *July 17, 1915*, that I saw him alive on *July 16, 1915*, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis(Duration) *3* yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Myocarditis

(Duration) — yrs. — mos. — ds.

(Signed) *E. J. ... M. D.**July 11, 1915* (Address) *122 W. Lee St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Herring Bur

DATE OF BURIAL,

July 18, 1915

20-UNDERTAKER

J. Lerner + Bro Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *2* WARD)

2-FULL NAME

(Residence in Baltimore: No. *921 Fall St.* St. *30* yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

*white-*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widow*

6-DATE OF BIRTH,

May 15, 1873
(Month) (Day) (Year)

7-AGE,

42 yrs. 2 mos. 2 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer). *at home*

9-BIRTHPLACE, (State or Country),

Austria

10-NAME OF FATHER,

Joseph Letinski

11-BIRTHPLACE OF FATHER (State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Mary Pisor

13-BIRTHPLACE OF MOTHER (State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph Stolz (Son)*(Address) *921 Fall St*

JUL 18, 1915.

Filed..... 1915.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 17, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 26* 1915, to *July 17* 1915, that I saw him alive on *July 17* 1915, and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) *12* yrs.mos.ds.CONTRIBUTORY.....*Unresolvable*
(Secondary)(Duration) *2* yrs.mos.ds.(Signed) *C. V. Lintner* M. D......, 101... (Address) *St. Joseph's*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs.mos.ds. In the *30* yrs.mos.ds.Where was disease contracted, if not at place of death? *not known*Former or usual residence *921 Fall St*

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus Cemetery

DATE OF BURIAL,

July 19, 1915

20-UNDERTAKER

Ammonius Denny & Co

ADDRESS

715 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *1710 Fr. Lexington St.* ST. *19* WARD)

2 FULL NAME *Albert Fletcher Dean*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1710 Fr. Lexington* St.; - yrs. *10* mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*

4 COLOR OR RACE *White*

5 SINGLE, *Single*

(Write the word)

6 DATE OF BIRTH *Sept. 6, 1914*

(Month)

(Day)

(Year)

7 AGE *10* yrs. *14* mos. *14* ds.

If LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country) *Maryland*

10 FATHER *Albert Dean*

PARENTS

11 BIRTHPLACE OF FATHER (State or country) *Delaware*

12 MAIDEN NAME OF MOTHER *Stella Stockman*

13 BIRTHPLACE OF MOTHER (State or country) *Ind.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Mrs. Albert E. Dean (Informant)

(Address) *1710 Fr. Lexington*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 18, 1915*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 11, 1915* to *July 17, 1915*

that I saw him alive on *July 17, 1915*

and that death occurred, on the date stated above, at *6:15* m.

The CAUSE OF DEATH* was as follows:

Intero-colitic

(Duration) - yrs. - mos. *10* ds.

Contributory (SECONDARY) *Intoxication*

(Duration) - yrs. - mos. *5* ds.

(Signed) *R. R. Harrison* M. D.

7/18, 1915 (Address) *165 E. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *London Park Cemetery*

DATE OF BURIAL *July 29, 1915*

20 UNDERTAKER *A. E. Hughes*

ADDRESS *17 S. Broadway*

15 JUL 18 1915

Filed ... 1915

HARRY O. ANDREWS

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hosp.* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *123 S. Clinton St.* yrs. *6* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH

(Month)

(Day)

(Year)

7-AGE

IF LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUL 18 1915 HARRY O. ANDERSON,
Filed..... 1915 Serial Permit. Clark.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 17 191*5*, to *July 17* 191*5*,that I saw him alive on *July 17* 191*5*,and that death occurred, on the date stated above, at *10 20 p.m.*

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial(Duration).....yrs.....mos.....*2* ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *John Hopkins Hosp.* M. D.*July 17* 191*5* (Address) *John Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....*1* ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence *123 S. Clinton St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Wm. Carroll *July 19, 1915*

20-UNDERTAKER

ADDRESS

Wendell Lippel Son *37 S. Ann St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *617 S. Bethel* ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Stanislav L. Kwiatkowski(Residence in Baltimore: No. *617 S. Bethel* St.;yrs. *7* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

Single

MARRIED, WIDOWED, or DIVORCED

(Write the word.)

6-DATE OF BIRTH,

*Sec**13**1914*

(Month)

(Day)

(Year)

7-AGE,

*7**5*

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Michael Kwiatkowski

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Helen Kuczyński

13-BIRTHPLACE OF MOTHER

(State or Country),

Balt.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Michael Kwiatkowski

(Address)

617 S. Bethel St.

15-

FILED

JUL 19 1915

ROBERT KRAUTER

BALTIMORE PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July 17**1915*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 16 191*5*, to *July 17* 191*5*that I saw her alive on *July 17* 191*5*and that death occurred, on the date stated above, at *5 p.m.*

The CAUSE OF DEATH* was as follows:

Gastric Enteritis(Duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. *1* ds.(Signed) *J. H. Adams* M. D.191*5* (Address) *1437 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Holy Rosary**July 19* 191*5*

UNDERTAKER

ADDRESS

William Tachowski *1618 Eastern Ave*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 837 S. Bond ST.: 2 WARD) REGISTERED No. C
2-FULL NAME Agnes Kobus (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. 837 S. Bond St.: 4 5 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <u>Female</u>	4-COLOR OR RACE, <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Single</u>
6-DATE OF BIRTH, <u>July</u> <u>5</u> , 191 <u>5</u> (Month) (Day) (Year)		
7-AGE, <u>5</u> yrs. <u>5</u> mos. <u>13</u> ds.		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work... (b) General nature of industry, business, or establishment in which employed (or employer)...		
9-BIRTHPLACE, (State or Country), <u>Baltimore</u>		
PARENTS.	10-NAME OF FATHER, <u>Frank Kobus</u>	
	11-BIRTHPLACE OF FATHER (State or Country), <u>Russia</u>	
	12-MAIDEN NAME OF MOTHER <u>Maria Teluslowicz</u>	
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Russia</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Kobus
(Address) 837 S. Bond St.

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JUL 19 1915
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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86778

CERTIFICATE OF DEATH

105 C86778

1-PLACE OF DEATH

REGISTERED No. C.

CITY OF BALTIMORE: (No. *300 P. Vincent* ST. *19* WARD)

2-FULL NAME *Lawrence Rogers Sutton*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1B.)

(Residence in Baltimore: No. *300 P. Vincent* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *Colored* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *June 3, 1913*
(Month) (Day) (Year)

7-AGE *2* yrs. *1* mos. *14* ds. or min.?
If LESS than 1 day, hrs. min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
Baby

9-BIRTHPLACE (State or country) *Balto Md.*

10-NAME OF FATHER *Lawrence A. Sutton*

11-BIRTHPLACE OF FATHER (State or country) *Carroll Co. Md.*

12-MAIDEN NAME OF MOTHER *Mamie Ethel Rogers*

13-BIRTHPLACE OF MOTHER (State or country) *Balto. City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Lawrence A. Sutton*

(Address) *300 P. Vincent St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 17th, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 13, 1915* to *July 17, 1915*, that I saw him alive on *July 16, 1915*, and that death occurred, on the date stated above, at *6:20 P. m.*
The CAUSE OF DEATH* was as follows:

Gastro-Intestinal
(Duration) *about 8* yrs. mos. ds.

Contributory (SECONDARY) *None*
(Signed) *C. Lincoln Tucker* M. D.
July 17, 1915 [Address] *333 S. Gilman St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Odd Fellows Cemetery *July 19, 1915*

20-UNDERTAKER *Alfred Freehand* ADDRESS *114 Freehand*

in Schroeder

15- *JUL 19 1915* *ROBERT J. GRIFFIN*
Filed 191 *1241 North Clark*
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86779

CERTIFICATE OF DEATH.

47 C86779

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1733 Hollins*ST.: *19*

WARD)

REGISTERED NO. C

2-FULL NAME

Peter Rush

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1733 Hollins*St.: *73* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

Married
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Unknown, *1834*
(Month) (Day) (Year)

7-AGE,

81

yrs. — mos. — ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Retired R.R. Engineer*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

Michael Rush

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. C. J. Tharle*(Address) *1733 Hollins St.*

15-

JUL 19 1915

DEERT

BRAUTER,

Filed.....

191

Official Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 16, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 10, 1915* to *July 16, 1915*, that I saw him alive on *July 16, 1915*, and that death occurred, on the date stated above, at *11 P. m.*

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism

(Duration)..... yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. — mos. — ds.

(Signed) *W. B. Smith* M. D.*July 17, 1915* (Address) *1184 Calhoun*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*JUL 19 1915**Cella Cemetery*

20-UNDERTAKER

ADDRESS

Geo. A. Gerbig Bacteriologist

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hospital* ST.; *10* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1107 Proctor St.* St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

female

4-COLOR OR RACE

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

6-DATE OF BIRTH

Oct. 8, 1915
(Month) (Day) (Year)

7-AGE

5 yrs. *7* mos. *7* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*none*

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Charles Migliore

11-BIRTHPLACE OF FATHER (State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Lula Migliore

13-BIRTHPLACE OF MOTHER (State or Country),

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lula Migliore*(Address) *1107 Proctor St*

JUL 19 1915

Filed, 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 17, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY That I attended deceased from *July 17, 1915*, to *July 17, 1915*, that I saw her alive on *July 17, 1915*, and that death occurred, on the date stated above, at *8 a. m.*

The CAUSE OF DEATH* was as follows:

Intestinal Intoxication(Duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Ernest H. Kiezer* M. D.*July 17, 1915* (Address) *St Josephs Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *1 1/2* hrs. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? *1107 Proctor St*Former or usual residence *do*

19-PLACE OF BURIAL OR REMOVAL,

Gen Cathedral

DATE OF BURIAL,

7-19, 1915

20-UNDERTAKER

Mr. M. Gantroy

ADDRESS

1624 My Royal Ave

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86781

C86781

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 Arsquith ST. 9

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1300 Arsquith

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

1848 (Month) (Day) (Year)

7-AGE,

6 yrs., mos., ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Ireland

10-NAME OF FATHER,

John O'Connell

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary Clark

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. Gorton

(Address) 1300 Arsquith St.

15 JUL 19 1915

W. E. KROGER

Filed....., 1915. Special Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 17, 1915. (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 3 1915, to July 17 1915, that I saw h. alive on July 16 1915, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Coronary atherosclerosis & high blood pressure

(Duration) ... yrs. ... mos. ... ds.

(Signed) Bernard Weiss M. D.

17, 1915. (Address) 111 E. 2nd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL

July 20, 1915

20-UNDERTAKER

A. M. Gauthier 1624

ADDRESS

Mt. Royal Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PERMIT, WITH UNPAID FEE, THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86782

CERTIFICATE OF DEATH

14

C86782

1 PLACE OF DEATH

REGISTERED NO. C

8

CITY OF BALTIMORE (No. 524 N Eden ST.)

WARD 5

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Woodley Williams

(Residence in Baltimore: No. 524 N Eden

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED OR DIVORCED married

6 DATE OF BIRTH unknown; 1 (Month) (Day) (Year)

7 AGE 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Laborer (b) General nature of industry, business, or establishment in which employed (or employer) General

9 BIRTHPLACE (State or country) New Orleans La.

PARENTS 10 NAME OF FATHER Dont Know 11 BIRTHPLACE OF FATHER (State or country) Dont Know 12 MAIDEN NAME OF MOTHER Dont Know 13 BIRTHPLACE OF MOTHER (State or country) Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Jane Williams (Address) 524 N Eden St

15 JUL 19 1915 ROBERT KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 15, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1915, to July 15, 1915, that I saw him alive on July 14, 1915, and that death occurred, on the date stated above, at 7-10 P.M. The CAUSE OF DEATH* was as follows:

Dysentery or Diarrhea

Contributory (SECONDARY) Old age (Duration) yrs. mos. 17 ds.

(Signed) J. H. Heard M.D. July 17, 1915 (Address) 202 Chesapeake St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL National 20 DATE OF BURIAL July 19, 1915

20 UNDERTAKER Robt A Elliott 506 East St ADDRESS

WRITE PERMANENT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86783

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED OR DIVORCED married (If write the word)

6 DATE OF BIRTH Unknown, 1847 (Month) (Day) (Year)

7 AGE 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Jm Adams

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Stewart

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Sembley (Address) 1020 Helmer

15 JUL 19 1915 DEPT. OF HEALTH REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 16, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1915, to July 16, 1915, that I saw her alive on July 16, 1915, and that death occurred, on the date stated above, at 4 P. m. The CAUSE OF DEATH* was as follows:

Myocardial degeneration of heart

(Duration) yrs. 6 mos. ds.

Contributory (SECONDARY) Asthenia

(Duration) yrs. 6 mos. ds.

(Signed) William E. Bunting M. D. July 18, 1915 (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Auburn

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Samuel T. Hensley 578 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86784

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *General German aged home* ST. *20* WARD)

2-FULL NAME

(Residence in Baltimore: No. *General German aged home* St. *40* yrs. *—* mos. *—* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

W

5-MARRIAGE

Widow
(Write the word.)

6-DATE OF BIRTH

Unknown, 1
(Month) (Day) (Year)

7-AGE

78 yrs. *—* mos. *—* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Germany.*

10-NAME OF FATHER,

*Fritz Keeser*11-BIRTHPLACE OF FATHER
(State or Country),*Germany.*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Information)

(Address)

Records. General German aged home
Baltimore, E. Cay St.

15-

JUL 19 1915

Filed.....

SEERT. KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, *17*, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Nov 12 191*3*, to *July 17* 191*5*,
that I saw h *er* alive on *July 10* 191*5*,
and that death occurred, on the date stated above, at *6:30* p.m.
The CAUSE OF DEATH* was as follows:*Organic Heart Disease*
(Duration) *2* yrs. *—* mos. *—* ds.CONTRIBUTORY
(Secondary)(Signed) *F. W. Hobbs* M. D.
July 18, 191*5*. (Address) *1908 N. Balt. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *7* yrs. *—* mos. *—* ds. In the State *40* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Baltimore Cen

20-UNDERTAKER

John Brooks

DATE OF BURIAL.

July 18, 191*5*

ADDRESS

1003 N. Balt St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE, (No. *8*)

2-FULL NAME

(Residence in Baltimore: No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *12* yrs., *11* mos. *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....

JUL 19 1915

No. *1029*

ROBERT E. KRAUTER

Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17 I HEREBY CERTIFY, That I attended deceased from

June 20, 1915, to July 18, 1915,

that I saw her alive on July 17, 1915,

and that death occurred, on the date stated above, at 12:20 A.M.

The CAUSE OF DEATH* was as follows:

Uterine Infection with toxic
ovarian abscess (Colon Bacillus)
following labor.
(Duration)..... yrs. mos. *28* ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. *7* ds.

(Signed)..... M. D.

July 18, 1915 (Address)..... Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. *29* ds. In the State..... yrs. mos. ds.Where was disease contracted, if not at place of death? *328 N. Gay St.*Former or usual residence *328 N. Gay St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hehren Washing Rd..... *7/19*, 1915

20-UNDERTAKER

ADDRESS

*Jack Lewis**1419 E. Sad*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Mt. General Hospital* REGISTERED No. C
 CITY OF BALTIMORE: (No. *Gr. Madison & Linden St.* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME *Charles Warner*
 (Residence in Baltimore: No. *2115 Walbrook Ave* St.; *12* yrs., *12* mos., *12* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
 (Write the word.)
 6-DATE OF BIRTH. *Nov 26*, 18*55*
 (Month) (Day) (Year)
 7-AGE. *59* yrs., *6* mos., *23* da. If LESS than 1 day, hrs. or min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Carpenter*
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Barroll Co Md.*
 10-NAME OF FATHER, *Jesse Warner*
 11-BIRTHPLACE OF FATHER (State or Country), *Md.*
 12-MAIDEN NAME OF MOTHER *Lathrine Legal*
 13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Sarah Warner*
 (Address) *2115 Walbrook Ave*

15- JUL 19 1915

Filed....., 191.....

ROBERT KRAUTER
 Special Permit Clerk
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *July 19*, 191*5*
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *July 14*, 191*5*, to *July 19*, 191*5*, that I saw him alive on *July 19*, 191*5*, and that death occurred, on the date stated above, at *1.05 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
 (Duration)..... yrs. mos. da.

CONTRIBUTORY (Secondary) *Cardiac Abilitation*
 (Duration)..... yrs. mos. da.

(Signed) *C. E. C. Hull* M. D.
July 19, 191*5*. (Address) *Mt. Gen. Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. da. In the State..... yrs. mos. da.

Where was disease contracted, *2115 Walbrook Ave*
 if not at place of death?

Former or usual residence *2115 Walbrook Ave*

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL.

Barroll Co Md *July 21*, 191*5*
 20-EMERALD ADDRESS

Robert Krauter 1723 W. ...

N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

86783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103

86783

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *510 S. Durham*)

ST.:

WARD)

REGISTERED NO. C

2-FULL NAME

George Adam Whitman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *510 S. Durham St.*)

St.; yrs., *40* mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, *Widowed*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Nov

12th

1840

(Month)

(Day)

(Year)

7-AGE,

74

Yrs. *8* mos. *5* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Retired Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

General Iron Works

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER (State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Mathie Webb

(Address).....

510 S. Durham St.

15-

JUL 19 1915

Filed.....

191.....

ROBERT KRAUTER

Regist.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

17th

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*
(Inquest, au-

topsy and that said deceased came to *his* death
(topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

Heat

(Duration)..... yrs. mos. ds.

(Signed).....

W. J. Jones

(Coroner.)

July 17, 1915 (Address)..... *3116 O'Donnell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mount Carmel

DATE OF BURIAL,

July 18, 1915

20-UNDERTAKER

Lilly Zeiler

ADDRESS

403 S. Wolfe St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital*)

2-FULL NAME

(Residence in Baltimore: No. *2738 Mosher St*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Unknown; 1865

(Month) (Day) (Year)

7-AGE,

60

yrs. mos. ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Columbia, Pa.

10-NAME OF FATHER,

Chas Zeidler

11-BIRTHPLACE OF FATHER (State or Country),

Penn.

12-MAIDEN NAME OF MOTHER

Mary Margurand

13-BIRTHPLACE OF MOTHER (State or Country),

Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *L. W. Smith*(Address) *2738 Mosher St*

15-

JUL 19 1915

SECRET

KROUTER

Filed

1915

Baltimore

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**17**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 13* 1915, to *July 17* 1915, that I saw her alive on *July 12* 1915, and that death occurred, on the date stated above, at *7:05* p.m.

The CAUSE OF DEATH* was as follows:

*Obstruction**operation*(Duration) ... yrs. ... mos. *10* ds.

CONTRIBUTORY (Secondary)

Carcinoma of Rectum(Duration) *3* yrs. ... mos. ... ds.(Signed) *R. L. Johnson**July 13, 1915*(Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs. mos. ds.

4

In the

State

27

yrs. mos. ds.

Where was disease contracted, if not at place of death?

Baltimore

Former or usual residence

2738 Mosher St

19-PLACE OF BURIAL OR REMOVAL

Harvard Place

DATE OF BURIAL

July 20, 1915

20-UNDERTAKER

C. A. Widgfeld

ADDRESS

Chas. M. M.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S MODE OF STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. 4 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF
FATHER11-BIRTHPLACE
OF FATHER
(State or country)12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

FILE

HERBERT KRAUTER

Social Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 C86792

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 720 N. Bruce street,

ST. 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barnstiel Schaney,

(Residence in Baltimore: No. 720 N. Bruce street,

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, March 13th, 1915. (Month) (Day) (Year)

7-AGE, 0 yrs., 4 mos., 4 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Edward Schaney,

11-BIRTHPLACE OF FATHER, Washington, D. C. (State or Country),

12-MAIDEN NAME OF MOTHER, Lucy Lawson,

13-BIRTHPLACE OF MOTHER, Baltimore, Md. (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Schaney, mother,

(Address) 720 N. Bruce street.

15- JUL 19 1915. ROBERT KRAUER, Registrar.

Filed 191. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 17th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis.

(Duration) yrs. mos. ds.

CONTRIBUTORY Artificially fed, (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Hempel, M. D. (Coroner.)

July 19, 1915. (Address) 3310 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

UNDERTAKER ADDRESS

James H. Lane 1303 B... ..

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1622 Marshall* ST.: *23* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Geo. E. Deems*(Residence in Baltimore: No. *1622 Marshall* St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Single*

6-DATE OF BIRTH,

April 29, 1915
(Month) (Day) (Year)

7-AGE,

2 yrs. 19 mos. 19 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Md.*

PARENTS.

10-NAME OF FATHER,

*Walter Deems*11-BIRTHPLACE OF FATHER
(State or Country),*Md.*

12-MAIDEN NAME OF MOTHER

*Annie Rasmussen*13-BIRTHPLACE OF MOTHER
(State or Country),*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. W. Deems*(Address) *1622 Marshall St.*

15-

JUL 19 1915

W. E. KAUFER,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 18, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *July 4, 1915*, to *July 18, 1915*, that I saw him alive on *July 18, 1915*, and that death occurred, on the date stated above, at *11 A. m.*

The CAUSE OF DEATH* was as follows:

*Mal - Nutritive*CONTRIBUTORY
(Secondary)*Exhaustion*
(Duration) yrs. mos. ds. *4*
(Signed) *R. P. Campbell* M. D.
July 18, 1915 (Address) *1622 Marshall St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Mary's bur. Soc. *7/20, 1915*

20-UNDERTAKER

ADDRESS

J. F. McCall *39 E. Fort Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST. *1* WARD)

2-FULL NAME

(Residence in Baltimore: No. *2221 E. Baltimore* St.; *30* yrs., *0* mos., *0* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH.

July 12, 1886
(Month) (Day) (Year)

7-AGE,

68

yrs. mos. ds.

If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Physician*9-BIRTHPLACE,
(State or Country),*Ohio*

10-NAME OF FATHER,

*Jno. P. Corradi*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER,

*Annie Spring*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Wilhelmina Corradi*(Address) *2221 E. Baltimore St.*

15- JUL 19 1915.

ROBERT KRAUTER,

Filed..... 1915.....
Special Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 17, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 12, 1915*, to *July 17, 1915*, that I saw him alive on *July 17, 1915*, and that death occurred, on the date stated above, at *8:30 P.M.*

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus and Carcinoma of Cecum
(Clinical Diagnosis & Sign)
Don't know (Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)*Intestinal Obstruction*
(Duration) yrs. mos. ds.
(Signed) *Frank M. Mays* M. D.*July 17, 1915*. (Address) *Mary Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. *6* ds. In the State..... yrs. *20* mos. ds.Where was disease contracted, if not at place of death? *Don't know*Former or usual residence *2221 E. Baltimore*

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

July 20, 1915

20-UNDERTAKER

Sander Sons

ADDRESS

1741 East St.

N. B.—Every item of information should be carefully supplied. Also, inform of death to nearest relatives. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86795

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86795

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

JUL 19 1915

DEPT. OF HEALTH
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at 8 p. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum
Chronic diarrhoea

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *1005 Leaden hall* St. *23* WARD)

2-FULL NAME *John W Brown*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN or No. 18.)

(Residence in Baltimore: No. *1005 Leaden hall* St. yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Col

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widower

6-DATE OF BIRTH

June 5, 1868
(Month) (Day) (Year)

7-AGE

47 yrs. mos. ds. or min.?

If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Day Laborer

9-BIRTHPLACE
(State or country)

Maryland

10-NAME OF FATHER

James Brown

11-BIRTHPLACE OF FATHER
(State or country)

md

12-MAIDEN NAME OF MOTHER

Rista Hall

13-BIRTHPLACE OF MOTHER
(State or country)

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Percy Giddings*

(Address) *1005 Leaden hall St*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 16, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 5, 1915, to, July 16, 1915,

that I saw h. *live* alive on *July 16, 1915,*

and that death occurred, on the date stated above, at *2:30 P.* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

Clinical Duration (Duration) yrs. *8* mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed), *A. J. M. Clark* M. D.

717, 1915. [Address] *205 S. ...*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

mt Auburn

July 19, 1915

20-UNDERTAKER

ADDRESS

John H. Treadway 142 W. Hill

15-

JUL 19 1915

JOHN H. TREADWAY, REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4*)

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *674 W. Fayette St.*)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOW,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

Aug 14, 1849
(Month) (Day) (Year)

7-AGE.

*65 yrs. 11 mos. 3 ds.*If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Painter
House*

9-BIRTHPLACE.

(State or Country).

MD

10-NAME OF FATHER.

Edward Lockwood

11-BIRTHPLACE OF FATHER.

(State or Country).

England

12-MAIDEN NAME OF MOTHER.

Elizabeth Simmons

13-BIRTHPLACE OF MOTHER.

(State or Country).

Paenna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....

*JUL 19 1915**BERT KRAUTER**Capital Service Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 17, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 6, 1915* to *July 17, 1915*, that I saw him alive on *July 17, 1915* and that death occurred, on the date stated above, at *11:45 P.M.*

The CAUSE OF DEATH* was as follows:

Cortic Regurgitation
Don't know
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)(Duration).....yrs.....mos.....ds.
(Signed).....*Edward Smith*.....M. D.
July 17, 1915 (Address).....*Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? *674 W. Fayette St.*Former or usual residence *674 W. Fayette St.*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St Peter Cemetery *July 20, 1915*

20-UNDERTAKER

ADDRESS *57 N.**Henry C. Breunig* *57 N. Sch road St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

086793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 086793
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 Eastern Ave ST. 3

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Wm A. Falkenhan

(Residence in Baltimore: No. 1518 Eastern Ave

St.; yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, Married, Widowed, or Divorced, (Write the word.)
Single

6-DATE OF BIRTH,

Feb.

21st

1915

(Month)

(Day)

(Year)

7-AGE,

4 mos. 27 ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE, (State or Country),

Ballo.

10-NAME OF FATHER,

Caspar Falkenhan

11-BIRTHPLACE OF FATHER (State or Country),

Ballo.

12-MAIDEN NAME OF MOTHER

May Davis

13-BIRTHPLACE OF MOTHER (State or Country),

Ballo.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) May Falkenhan

(Address) 1518 Eastern Ave

15-

JUL 19 1915

DEPT. KRAUTER

Filed

191

Burial Permit 510

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

18th

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 3 1915, to July 18 1915, that I saw him alive on July 17 1915, and that death occurred, on the date stated above, at 7³⁰ P.M.

The CAUSE OF DEATH* was as follows:

Eastern enteritis
(Duration) yrs. 7 mos. 6 mos.
CONTRIBUTORS Eastern enteritis
(Secondary) (Duration) yrs. 6 mos.
(Signed) Geo. Heller M. D.
1915 (Address) 1937 E. 19th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Carmel

DATE OF BURIAL,

July 19th 1915

20-UNDERTAKER

Hurdell Lippel & Son

ADDRESS

37 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86799

CERTIFICATE OF DEATH

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 112, Riggs ave

ST. 16 WARD)

2-FULL NAME

Mary Munday (Munday)
1121 1/2 Riggs Ave

(Residence in Baltimore: No.

Str.: yrs. mos. 12 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-MARRIED

Married

(Write the word)

6-DATE OF BIRTH

Unknown, 1893
(Month) (Day) (Year)

7-AGE

52

yrs.

mos.

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework
General

9-BIRTHPLACE
(State or country)

A. A. Co Md

PARENTS

10-NAME OF FATHER

James Gross

11-BIRTHPLACE OF FATHER
(State or country)

Md

12-MAIDEN NAME OF MOTHER

Mary Brooks

13-BIRTHPLACE OF MOTHER
(State or country)

Ma

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jab. Gross
A. A. Co Md

15.

FILE

JUL 19 1915

ROBERT . KRAUTER

Chief Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 17, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from

July 8, 1915, to July 17, 1915.

that I saw him alive on July 17, 1915.

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Contributory
(SECONDARY)

(Duration) 1 yrs. mos. ds

(Signed),

G. E. Plunk M. D.

July 18, 1915. (Address) 2000 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Magothy A. A. Co Md

July 17, 1915

20-UNDERTAKER

Sam H. Chase & Son

ADDRESS

1400 7th St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

IF LESS than 1 day, hrs. & min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

JUL 19 1915

ROBERT K. KREUER

Surgeon General

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) J. W. Jones M. D.

July 19, 1915 (Address) 216 Vermont St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2224 Essex* ST.; *1* WARD)

2-FULL NAME

(Residence in Baltimore: No. *2224 S. Essex St.* yrs. *8* mos. *ds*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

Nov
(Month)*13*, *1914*
(Day) (Year)

7-AGE.

8 yrs. *6* mos. *6* ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.

(State or Country).

Baltimore Md.

10-NAME OF FATHER.

Thomas Ratajczak

11-BIRTHPLACE OF FATHER

(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Mary Kzadoszek

13-BIRTHPLACE OF MOTHER

(State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Thomas Ratajczak

(Address).

2224 Essex St.

15-

*JUL 19 1915**HEBERT KRAUTER**Special Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July
(Month)*19*, *1915*
(Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

July 2, *1915*, to *July 19*, *1915*,that I saw him alive on *July 19*, *1915*,and that death occurred, on the date stated above, at *1507* in.

The CAUSE OF DEATH was as follows:

Pneumonia(Duration) yrs. *Unknown*

CONTRIBUTORY (Secondary)

(Duration) yrs. *None* ds.(Signed) *J. J. Janowski* M. D.*July 19*, *1915* (Address) *2431 Patton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

St. Stanislaus

DATE OF BURIAL.

July 20, *1915*

ADDRESS

705 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 253 S. Register)

2-FULL NAME

(Residence in Baltimore: No. 253 S. Register)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 16 yrs., 13 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH

July 4, 1899
(Month) (Day) (Year)

7-AGE

76 yrs., 13 mos., 13 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Balto. Md.

10-NAME OF FATHER,

Geo. Rudzinski

11-BIRTHPLACE OF FATHER (State or Country),

Russian Poland

12-MAIDEN NAME OF MOTHER

Iva Szrakowski

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Geo. Rudzinski,
253 S. Register St.

15-

Filed JUL 19 1915

ROBERT

KRAUTER

Registrar.

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus,

UNDERTAKER

M. J. Sadowski

DATE OF BURIAL

July 20, 1915

ADDRESS

705 S. Ann

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH,

July 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1914, to July 17, 1915, that I saw him alive on July 17, 1915, and that death occurred, on the date stated above, at 7:15 P. M.

The CAUSE OF DEATH* was as follows:

Endocarditis

CONTRIBUTORY (Secondary)

Pneumonia

(Signed) Geo. S. Heller, M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death: yrs. mos. ds. In the State: yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Eleg. Clark.
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the words)

6-DATE OF BIRTH.

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

JUL 19 1915

ROBERT A. KRAUTER

Supt. of Health

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed) ... M. D.

... (Address) ...

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... In the ... State ...

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. *1* mos. *14* ds)

MEDICAL CERTIFICATE OF DEATH.

5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

..... May 21, 1915
(Month) (Day) (Year)

...yrn... 1 ...mos... 26 da

If LESS than 1 day,
....hrs. or....min.?

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

PARENTS.

11-BIRTHPLACE
OF FATHER
(State or Country).

12-MAIDEN NAME
OF MOTHER

**13-BIRTHPLACE
OF MOTHER
(State or Country).**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*St Vincent's*.....

(Address) ... 1401 Division St.

15 JUL 19 1915

Filed.....

ROBERT KRAUTER

Permit to Operate

Registrar.

..... July 17, 1915

17- I HEREBY CERTIFY, That I attended deceased from

July 1st 1915, to July 17 1915,
that I saw her alive on July 17 1915,
and that death occurred, on the date stated above, at 6⁰⁰ p. m.

The CAUSE OF DEATH* was as follows:

In abnutrition and
In al assimilation
(Duration) . . . yrs. 1. mo. 24. da.

CONTRIBUTORY
(Secondary)

..... (Duration) yrs. mon. da.

(Signed) J. P. Ardison M. D.

July 18, 1915. (Address) 615 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 14 ds. In the State yrs. 1 mos. 26 ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

12-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Leatherstocking July 19, 1915.

ADDRESS

20-UNDERTAKER	ADDRESS
W. Fahey & Sons	606 Lafayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Chrift Asy* ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Chrift Asylum* St. yrs. 1 mos. 12 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)

6-DATE OF BIRTH, *June 9, 1915* (Month) (Day) (Year)

7-AGE, *1. mos. 14. ds.* If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Maryland

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*

(Address) *1401 Division St.*

15-

JUL 19 1915 *ROBERT KRAUTER*

Filed. 191. *Permit Clerk* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 17, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 15, 1915*, to *July 16, 1915*, that I saw her alive on *July 16, 1915*, and that death occurred, on the date stated above, at *5.30 a.m.*

The CAUSE OF DEATH* was as follows:

Malnutrition & Malassimilation

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. E. Roulier* M. D.*July 18, 1915* (Address) *615 Columbus Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 12 ds. In the State yrs. 1 mos. 14 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

July 19, 1915

20-UNDERTAKER

ADDRESS

Off. F. & Sons 606 Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1606 N Wolfe

FULL NAME

Edward N Sneed

(Residence in Baltimore: No. 1606 N Wolfe

ST. 8

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Dec

5th

1879

(Month)

(Day)

(Year)

7-AGE,

65

yrs.

5

mos.

13

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Paper Hanger

9-BIRTHPLACE,

(State or Country),

Md

10-NAME OF FATHER,

Richard Sneed

11-BIRTHPLACE OF FATHER

(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Hattie A. Sneed

(Address)

1606 N Wolfe St

15-

FILED

JUL 19 1915

HARRY O. ANDREWS,

Marial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

19th

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

Inquiry And that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Elijah J. Russell M. D.

(Coroner.)

July 19, 1915 (Address) 423 N Broadway

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Under the

ADDRESS

Under the

ADDRESS

Under the

ADDRESS

Under the

ADDRESS

Under the

ADDRESS

Under the

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.; *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Middlesex Va* St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Black*5-SINGLE
MARRIED
WIDOWED
OR DEPOSED.
(Write the word.)
Widowed

6-DATE OF BIRTH.

June 10, 1889
(Month) (Day) (Year)

7-AGE.

26 yrs. *0* mos. *28* ds.
If LESS than 1 day,hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housework*
*General*9-BIRTHPLACE.
(State or Country),*Va*

10-NAME OF FATHER,

*Richard Page*11-BIRTHPLACE OF FATHER
(State or Country),*Va*

12-MAIDEN NAME OF MOTHER

*Not known*13-BIRTHPLACE OF MOTHER
(State or Country),*Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Record Mercy Hosp*(Address) *Calvert St*

15-

JUL 19 1915

HARRY O. ANDREWS,

Filed....., 191... *Serial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 8, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 13* 191*5*, to *July 8* 191*5*, that I saw her alive on *July 8* 191*5* and that death occurred, on the date stated above, at *11:00* m.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis
Chorea
(Duration) *2* yrs. *10* mos. *10* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yr. *10* mos. *10* ds.
(Signed) *Edward J. Smith* M. D.
July 9, 1915 (Address) *Mercy Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. *28* mos. *28* ds. In the State..... yrs. *28* mos. *28* ds.

Where was disease contracted, if not at place of death?

Middlesex Va

Former or usual residence

Middlesex Va

19-PLACE OF BURIAL OR REMOVAL,

PUBLIC CEMETERY.

DATE OF BURIAL.

JUL 19 1915

20-UNDERTAKER

Commissioner Health

ADDRESS

Per. Wm. E. WOODALL,

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hosp* ST. *11* WARD)

REGISTERED NO. C.

2-FULL NAME

(Residence in Baltimore: No. *None* (South River Md) St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUL 19 1915

HARRY O. ANDREWS,

Filed..... 191.....

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

March 24 1915, to June 28 1915,

that I saw him alive on June 28 1915,

and that death occurred, on the date stated above, at 1-P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
& T.B. of (Right) Head of Femur.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) William J. Blanchard, M. D.

June 28, 1915. (Address) Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? South River Ind

Former or usual residence South River Ind

19-PLACE OF BURIAL OR REMOVAL.

PUBLIC CEMETERY.

DATE OF BURIAL.

JUL 19 1915

20-UNDERTAKER

Commissioner Health.

ADDRESS

Per. Wm E. WOODALL.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *E. Falls Ave & Alameda* ST. *3* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Not known* St.; yrs., — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

Not known

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Not known*

6-DATE OF BIRTH,

Not known, 1 (Month) (Day) (Year)

7-AGE,

45 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Not known*
(b) General nature of industry, business, or establishment in which employed (or employer). *Not known*

9-BIRTHPLACE, (State or Country),

Not known

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER (State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUL 19 1915 *HARRY O. ANDREWS,*
Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, *30*, *1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said... (Inquest, au-

topsy or inquiry.) and that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Accidental Drowning
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D. (Coroner.)

July 16, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

PUBLIC CEMETERY

DATE OF BURIAL,

JUL 19 1915

20-UNDERTAKER

Commissioner Health,

ADDRESS

Prof. Wm. E. WOODALL,

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Marine Hospital* REGISTERED NO. C
CITY OF BALTIMORE (No. *12*) WARD (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Robert - Luntins*
(Residence in Baltimore: No. *did not live here*) St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *m* 4-COLOR OR RACE *negro* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH *Don't know*, 1891 (Month) (Day) (Year)
7-AGE *24* yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Farmer in steam boat.* (b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), *Don't know*
10-NAME OF FATHER, " "
11-BIRTHPLACE OF FATHER (State or Country), " "
12-MAIDEN NAME OF MOTHER, " "
13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Marine Hospital*

(Address) *Remedy Street*

15- JUL 19 1915 HARRY O. ANDREWS, Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 9th*, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry* and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Whole body scalded with steam from a broken boiler. (Duration) yrs. mos. ds. (Signed) *Harry O. Andrews* M. D. (Coroner) July 17, 1915 (Address) *2600 Beland St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY DATE OF BURIAL, JUL 19 1915

20-UNDERTAKER ADDRESS

Commissioner Health.

C86811 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____ ST.: _____ WARD) _____

2-FULL NAME

(Residence in Baltimore: No. _____ St.: _____ yrs. _____ mos. _____ ds.)

REGISTERED NO. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH,

_____, 1886
(Month) (Day) (Year)

7-AGE

29

yrs. _____ mos. _____ ds.

If LESS than 1 day,

____ hrs. or _____ min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Labour

General

9-BIRTHPLACE,
(State or Country),

District of Columbia

10-NAME OF FATHER,

Wm Thomas

11-BIRTHPLACE OF FATHER
(State or Country),

Washington D. C.

12-MAIDEN NAME OF MOTHER

Elizabeth ??

13-BIRTHPLACE OF MOTHER
(State or Country),

Wash. D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) _____

(Address) _____

15-

JUL 19 1915

HARRY O. ANDREWS,

Filed

Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

_____, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

_____, 1915, to _____, 1915,

that I saw him alive on _____, 1915,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Labour)

(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

Cardio - vasc. failure

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 1915 (Address) _____

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL,

PUBLIC CEMETERY.

DATE OF BURIAL,

JUL 19 1915.

20-UNDERTAKER

Commissioner Health.

ADDRESS

Per. Wm. E. WOODALL.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Turned over to City June 22nd 2 PM.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Unknown*)

2-FULL NAME

Unknown

(Residence in Baltimore: No. *Unknown*)

found in a Eugene & Carter st.

REGISTERED No. C

ST. *8*

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH,

Unknown, 1

(Month) (Day) (Year)

7-AGE,

about 10 yrs. mos. ds.

IF LESS than 1 day, hrs. or min.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

9-BIRTHPLACE,

(State or Country),

Unknown

PARENTS.

10-NAME OF FATHER,

"

11-BIRTHPLACE OF FATHER (State or Country),

"

12-MAIDEN NAME OF MOTHER

"

13-BIRTHPLACE OF MOTHER (State or Country),

"

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUL 19 1915

HARRY O. ANDREWS,

Serial Form 1000

16-DATE OF DEATH

(Found dead July 11th)
Unknown, 191

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, an-

inquest and that said deceased came to death topy or inquiry on the day stated above.

The CAUSE OF DEATH* was as follows:

Unknown

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Colman J. Russell* M. D.

(Capacity)

July 11, 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

PUBLIC CEMETERY

JUL 19 1915

20-UNDERTAKER

ADDRESS

Commissioner Health,

Per. Wm. H. Woodhall

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1605 Orleans

2-FULL NAME

Roland Brady

(Residence in Baltimore: No. 1605 Orleans

ST:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWER, OR DIVORCED. (Write the word.)

Infant

6-DATE OF BIRTH,

April 30, 1915

7-AGE,

1 mos. 27 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE, (State or Country),

MD

10-NAME OF FATHER,

Wm. A. Brady

11-BIRTHPLACE OF FATHER (State or Country),

MD

12-MAIDEN NAME OF MOTHER

Catherine Brown

13-BIRTHPLACE OF MOTHER (State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

JUL 19 1915, Serial Permit Oler

Filed

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 26, 1915

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said inquest, autopsy or inquiry, I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Branch Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Russell, M. D.

June 28, 1915. (Address) 423 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

PUBLIC CEMETERY

JUL 19 1915

20-UNDERTAKER

ADDRESS

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

086814

HEALTH DEPARTMENT—CITY OF BALTIMORE

086814

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1)

2-FULL NAME

(Residence in Baltimore: No. 1)

University Md Hosp
Martini Doyle
Oxford Hotel

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

?

6-DATE OF BIRTH,

Unknown, 1

7-AGE,

55 (about)

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Unknown

9-BIRTHPLACE, (State or Country),

Unknown

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- JUL 19 1915

HARRY O. ANDREWS

Filed....., 191.....

Serial Permit. dler

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12, 1915

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Chr. hepatitis

(Signed)

(Duration) yrs. mos. ds.

M. D.

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the Unknown

Where was disease contracted, if not at place of death?.....

Oxford Hotel

Former or usual residence Oxford Hotel

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

PUBLIC CEMETERY.

JUL 19 1915

20-UNDERTAKER

ADDRESS

Commissioner Health.

Per. Wm. E. DODALL.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *526 East*

ST.:

WARD:

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Annie Allen*(Residence in Baltimore: No. *526 East*

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE. <i>colored</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <i>widowed</i>
6-DATE OF BIRTH. <i>unknown</i> , 1 (Month) (Day) (Year)		
7-AGE. <i>45</i> yrs. mos. ds.		8-LESS than 1 day. hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housework
General

9-BIRTHPLACE.
(State or Country),*va*

PARENTS.

10-NAME OF FATHER,

*unknown*11-BIRTHPLACE OF FATHER
(State or Country),*va*

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annie Allen*(Address) *526 East St.*

15-

Filed

*JUL 19 1915**HARRY O. ANDREWS**Marial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July (17th) 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 28* 1915, to *July 17* 1915, that I saw her alive on *July 17* 1915 and that death occurred, on the date stated above, at *7:34 P.*

The CAUSE OF DEATH* was as follows:

Alcoholitis and
Summer heat
3 weeks (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

valvular heart disease
(Duration) yrs. mos. ds.

(Signed) *Edward Fisher* M. D.

July 18, 1915 (Address) *1412 E. Monument St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Laurel *July 29 1915*

20-UNDERTAKER

ADDRESS

John Henderson *317 Caroline*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.; *2* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1626 Shakespeare* St.; *—* yrs., *—* mos., *1* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

16-DATE OF DEATH.

July 18, 1915
(Month) (Day) (Year)

6-DATE OF BIRTH.

July 18, 1915
(Month) (Day) (Year)

7-AGE,

— yrs., *—* mos., *—* da.

If LESS than 1 day.

2 hrs. or *—* min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *—*
(b) General nature of industry, business, or establishment in which employed (or employer). *—*

9-BIRTHPLACE,

(State or Country),

Ind.

PARENTS.

10-NAME OF FATHER,

Michael Faden

11-BIRTHPLACE OF FATHER

(State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Mary Godag

13-BIRTHPLACE OF MOTHER

(State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Michael Faden*(Address) *1626 Shakespeare St.*

JUL 19 1915

HARRY O. ANDREWS,

Filed..... 101... *Serial Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from *July 18, 1915*, to *July 18, 1915*, that I saw him alive on *July 18, 1915* and that death occurred, on the date stated above, at *12 P.m.*

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
Full term child lived
2 hours (Duration) *—* yrs., *—* mos., *—* da.

CONTRIBUTORY

(Secondary)

Difficult operative delivery (Duration) *—* yrs., *—* mos., *—* da.(Signed) *E. D. Glass* M. D.*July 18, 1915* (Address) *Johns Hopkins*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *—* yrs., *—* mos., *—* da. In the State *—* yrs., *—* mos., *—* da.Where was disease contracted, if not at place of death? *—*Former or usual residence *—*

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

July 20, 1915

ADDRESS

405 S. Sun

20-UNDERTAKER

M. F. Sadowski

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *267 Caroline* ST.: *5* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *267 Caroline St (in rear)* St.: *3* yrs., mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

Single
~~MARRIED~~
~~WIDOWED~~
~~OR UNMARRIED~~
(Write the word.)

6-DATE OF BIRTH,

November 17, 1886
(Month) (Day) (Year)

7-AGE,

28 yrs. *8* mos. — da.If LESS than 1 day,
....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

House-work
General

9-BIRTHPLACE,

(State or Country)

Baltimore County, Md.

10-NAME OF FATHER,

Henry Brown

11-BIRTHPLACE OF FATHER

(State or Country),

Balt Co, Md.

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country),

Not known.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Nathaniel Palmer*(Address) *267 Caroline St.*

15-

*Filed July 19 1915**HARRY O. ANDREWS,**191 Serial Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 18, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 18 1915*, to *July 18 1915*, that I saw her alive on *July 18 1915*, and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)..... yrs. mos. da.

CONTRIBUTORY.....

Acute gastritis
(Secondary).....(Signed) *Richard J. Eschinger* M. D.*July 19, 1915* (Address) *1514 E. Baltimore St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Asbury

DATE OF BURIAL,

July 20 1915

20-UNDERTAKER

John Henderson

ADDRESS

317 Caroline

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

McINTIRE

C86818

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 N. Pulaski

ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 423 N. Pulaski

St.; 38 yrs., 7 mos. 10 da)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) Married

6-DATE OF BIRTH,

Dec 7, 1876
(Month) (Day) (Year)

7-AGE,

38 yrs., 7 mos., 10 da.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Policemen
City9-BIRTHPLACE,
(State or Country).

Balto., Md.

10-NAME OF FATHER,

Patrick McIntire

11-BIRTHPLACE OF FATHER
(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Ellen Honahue

13-BIRTHPLACE OF MOTHER
(State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael J. Banaghan

(Address) 423 Pulaski St.

JUL 19 1915

Filed..... 191.....

HARRY O. ANDERSON

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1, 1915, to July 17, 1915,

that I saw him alive on July 17, 1915,

and that death occurred, on the date stated above, at 7 1/2 m.

The CAUSE OF DEATH* was as follows:

Aschemia

(Duration)..... yrs..... mos. 10 da.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... da.

(Signed) F. H. M. M. D.

July 18, 1915 (Address) 78 Baum

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Cathedral Cemetery

DATE OF BURIAL.

July 20, 1915

20-UNDERTAKER

R. & M. J. Flynn

ADDRESS

1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE: (No. *20* ST.; *20* WARD)
2-FULL NAME *Emily Myrtle Carter*
(Residence in Baltimore: No. *2756* W. *Lafayette Ave* St.; *0* yrs., *2* mos., *26* ds.)

REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)
6-DATE OF BIRTH, *July 2, 1915*
(Month) (Day) (Year)
7-AGE, *3* yrs., *2* mos., *16* ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Child*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*

PARENTS.

10-NAME OF FATHER, *John B. Carter*
11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*
12-MAIDEN NAME OF MOTHER, *Mary Griffith*
13-BIRTHPLACE OF MOTHER (State or Country), *Dayton Ohio*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Carter*
(Address) *2756 W. Lafayette*

JUL 19 1915 HARRY O. ANDREWS,
Filed, 191. *Parial Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, *July 18, 1915*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *July 18, 1915*, to *July 18, 1915*, that I saw him alive on *July 18, 1915*, and that death occurred, on the date stated above, at *7:50 p.m.*

The CAUSE OF DEATH* was as follows:

Pyelitis nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *A. S. Rothholz* M. D.

July 18, 1915 (Address) *2756 W. Lafayette Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the *3* yrs. mos. ds.

Where was disease contracted, if not at place of death? *2756 W. Lafayette Ave*

Former or usual residence *2756 W. Lafayette Ave*

19-PLACE OF BURIAL, OR REMOVAL, *Int. Oliver* DATE OF BURIAL, *7/20, 1915*

20-UNDERTAKER *William Cook* ADDRESS *502 E. North Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1112 N Fulton Ave* ST.; *16* WARD)2-FULL NAME *Louis Heinemann*(Residence in Baltimore: No. *1112 N Fulton Ave* St.; *50* yrs., *50* mos., *50* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

Married

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

May 11, 1893

(Month)

(Day)

(Year)

7-AGE,

72 yrs. 2 mos. 7 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Tailor men
Retired*

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

Dont Know

11-BIRTHPLACE OF FATHER (State or Country),

Dont Know

12-MAIDEN NAME OF MOTHER

Dont Know

13-BIRTHPLACE OF MOTHER (State or Country),

Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elizabeth Heinemann*(Address) *1112 N Fulton*

15-

Filed

JUL 19 1915

191

*HARRY C. ANDREWS,**Marial Park, Otor**Registrar.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 18, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Sub 24, 1915, to July 18, 1915,*that I saw him alive on *July 17, 1915,*and that death occurred, on the date stated above, at *6 a m.*

The CAUSE OF DEATH* was as follows:

*Anaemia from marion**about 5 yrs. 5 mos. 5 ds.*

CONTRIBUTORY (Secondary)

about 4 yrs. 4 mos. 4 ds.(Signed) *H. E. Knapp* M. D.*July 19, 1915. (Address) 1002 M. Lane*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Louder Park**July 21, 1915*

20-UNDERTAKER

ADDRESS

*William Cook**502 E. 1st St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

HARRY O. ANDREWS,

Serial Permit Alex. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY
(Secondary)

(Signed) P. W. Wilson M. D.

July 18, 1915 (Address) 2407 Washington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *Hebrew Hospital* ST. *7*)

WARD

2 FULL NAME *Salomon Kaufman (Kaufman)*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *Hebrew Hospital Home* Sr. *Unknown* yrs. *Unknown* mos. *Unknown* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*
(Write the word)

6 DATE OF BIRTH *Unknown, 1837*
(Month) (Day) (Year)

7 AGE *78* yrs. *Unknown* mos. *Unknown* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Germany*

10 NAME OF FATHER *Mr. Kaufman*

11 BIRTHPLACE OF FATHER (State or country) *Prussia*

12 MAIDEN NAME OF MOTHER *Not known*

13 BIRTHPLACE OF MOTHER (State or country) *Prussia*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 JUL 19 1915

HARRY O. ANDREWS

Filed

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 18, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 6, 1915*, to *July 18, 1915*, that I saw him alive on *July 18, 1915*, and that death occurred, on the date stated above, at *7:20 A.M.* The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. *12* mos. *12* ds.
Contributory *Hypertension*
(SECONDARY)

(Duration) yrs. *1* mos. *1* ds.
(Signed) *M. B. Levine* M. D.
(Address) *Hebrew Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. *12* mos. *12* ds. In the *Unknown* yrs. *Unknown* mos. *Unknown* ds.
Where was disease contracted? *Hebrew Hospital Home*
If not at place of death? *Unknown*
Former or usual residence *Unknown*

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Burial

July 20, 1915

20 UNDERTAKER

ADDRESS

David S. S. S.

1800 1st St. N.W.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Union Rev. Infirmary* REGISTERED NO. C *+82*
 CITY OF BALTIMORE: (No. *14*) ST.: *14* WARD: *14*
 2-FULL NAME *G. Frank Probst*
 (Residence in Baltimore: No. *Hickory N.C.* St.: *14* yrs. *1* mos. *1* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married*
 (Write the word.)
 6-DATE OF BIRTH, *July 15, 1873*
 (Month) (Day) (Year)
 7-AGE, *41* yrs. *11* mos. *3* ds. If LESS than 1 day,hrs. or....min.

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, *Farmer*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Hickory, North Carolina*
 10-NAME OF FATHER, *Henry Probst*
 11-BIRTHPLACE OF FATHER (State or Country), *Cataula Co. N.C.*
 12-MAIDEN NAME OF MOTHER, *Sarah Bunnigamer*
 13-BIRTHPLACE OF MOTHER (State or Country), *Cataula Co. N.C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant), *Records Union Infirmary*
 (Address), *1514 Lorraine St.*

15-*JUL 19 1915* HARRY O. ANDREWS,
 Filed *191* Serial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 18, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 14* 191*5*, to *July 18* 191*5*,
 that I saw him alive on *July 18* 191*5*,
 and that death occurred, on the date stated above, at *8:30 P.M.*

The CAUSE OF DEATH* was as follows:

Acute pneumonia
 (Duration) *2* yrs. *6* mos. *1* ds.

CONTRIBUTORY *Embolic pneumonia*
 (Secondary)

(Duration) *2* yrs. *6* mos. *1* ds.

(Signed) *Burns & Co. Dr.* M. D.

July 18, 1915 (Address) *Hickory N.C.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *4* mos. *4* ds. In the State yrs. *4* mos. *4* ds.

Where was disease contracted, if not at place of death? *Hickory N.C.*

Former or usual residence *Hickory N.C.*

19-PLACE OF BURIAL OR REMOVAL, *Hickory, N.C.* DATE OF BURIAL, *July 19, 1915*

20-UNDERTAKER, *Josh. Cook* ADDRESS, *103 N. Kato St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86821

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *517 N. Pulaski* ST.; *15* WARD)

REGISTERED NO. C.

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *517 N. Pulaski* St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

*Married**MARRIED,**WIDOWED,**OR DIVORCED,*

(Write the word.)

6-DATE OF BIRTH,

June 13, 1860
(Month) (Day) (Year)

7-AGE,

55 yrs. *1* mos. *4* da.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),*Maryland*

PARENTS.

10-NAME OF FATHER,

*Richard Leonard*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Catherine Wilson*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Howard E. Leonard M.D.
704 N. Carrollton Ave.

15-

*JUL 19 1915**HARRY O. ANDREWS*

Filed

191

Serial Permit 0107

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 17, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 20* 191*3*, to *July 17* 191*5*, that I saw her alive on *July 17* 191*5*, and that death occurred, on the date stated above, at *10:40* p.m.

The CAUSE OF DEATH* was as follows:

Uræmia

.....

(Duration) yrs. mos. da.
CONTRIBUTORY (Secondary) *Chronic Interstitial Nephritis*

(Signed) *Howard E. Leonard M.D.*
July 18, 1915 (Address) *704 N. Carrollton Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baldwin Memorial Cem. & Co. July 20, 1915.

20-UNDERTAKER

ADDRESS *S. S. Cor**Robt. Brooks Son & Co. Calhoun & Hollins**Sts.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86825

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86825

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2101* *Lamley*ST. *6* WARD)

REGISTERED NO. C

2-FULL NAME *Evelyn Seufert*(Residence in Baltimore: No. *2101* *Lamley*

St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)6-DATE OF BIRTH, *Feb 14, 1915*

(Month)

(Day)

(Year)

7-AGE, *5* yrs. *5* mos. *5* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Md*10-NAME OF FATHER, *George Seufert*11-BIRTHPLACE OF FATHER (State or Country), *Md*12-MAIDEN NAME OF MOTHER, *Christian Starklauff*13-BIRTHPLACE OF MOTHER (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *E. Seufert*(Address) *Fullerton Md*

15-JUL 19 1915.

Filed..... 191

Marial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 19, 1915*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *July 18, 1915*, to *July 19, 1915*, that I saw him alive on *July 19, 1915*, and that death occurred, on the date stated above, at *8:45 a.m.*

The CAUSE OF DEATH* was as follows:

Acute Illness - Colitis(Duration)..... yrs. mos. *25* ds.CONTRIBUTORY (Secondary) *Circulation*(Duration)..... yrs. mos. *1* ds.(Signed) *John L. O'Connell, M.D.*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. *John L. O'Connell, M.D.*

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Oak Lawn Cemetery*DATE OF BURIAL, *July 20, 1915*20-UNDERTAKER *Christian Miller*ADDRESS *2334 Jefferson*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. ST. 1* WARD)

REGISTERED NO. C

2-FULL NAME

Katie Haddaway

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1115 Chester St.* St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*married*

6-DATE OF BIRTH.

July 23, *1886*
(Month) (Day) (Year)

7-AGE.

28 yrs. *11* mos. *25* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business, or establishment in which
employed (or employer).*Housewife*9-BIRTHPLACE,
(State or Country),*md.*10-NAME OF
FATHER,*John Dornbacher*11-BIRTHPLACE
OF FATHER
(State or Country),*Germany*12-MAIDEN NAME
OF MOTHER*Mary Lantry*13-BIRTHPLACE
OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. J. Smith*(Address) *Johns Hopkins Hosp.*15. *JUL 19 1915**HARRY O. ANDERSON*

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 18, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
June 12 191*5*, to *July 18* 191*5*,
that I saw her alive on *July 18* 191*5*,
and that death occurred, on the date stated above, at *10:45* p.m.

The CAUSE OF DEATH* was as follows:

*Pulmonary Embolism**10 min.*
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY
(Secondary)*10*
days previously (Duration) ... yrs. ... mos. ... ds.

(Signed)

E. D. Pless M. D.*July 19, 1915* (Address) *Johns Hopkins Hosp.**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *8* mos. *8* ds. In the *28* yrs. *11* mos. *25* ds.Where was disease contracted,
if not at place of death?Former or
usual residence *1115 Chester St.*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Carmel Cemetery *July 23 1915*

20-UNDERTAKER

ADDRESS

Christian Miller *233 1/2 Jefferson*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 N. Glover ST. 6 WARD)

2-FULL NAME Archie L. Charlton

(Residence in Baltimore: No. *725 N. Glorv* St.; yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *Widow*
MARRIED, WIDOWED, OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH, November 1, 1867
(Month) (Day) (Year)

7-AGE, 47 yrs. 8 mos. 16 da. If LESS than 1 day, ...hrs. or...min.?

5-OCCUPATION:
(a) Trade, profession, or particular kind of work. *House work*
(b) General nature of industry, business, or establishment in which employed (or employer). *at home*

B-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER. *W. J. Smith*

11-BIRTHPLACE
OF FATHER
(State or Country). *Ind*

12-MAIDEN NAME
OF MOTHER

13-BIRTHPLACE
OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm C. Charlton

(Address) 725 N. Glenn St

18- JUL 19 1915 HARRY O. ANDREWS,
Filed Serial Patent Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July 18, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 18 1915, to July 18 1915,
that I saw her alive on July 18 1915,
and that death occurred, on the date stated above, at 11:00 p.m.

The CAUSE OF DEATH* was as follows:

Heart Stroke - 3 hrs. 55 min.
(Duration)..... yrs..... mos..... da.

CONTRIBUTORY.....
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Geo. A. Harmon M. D.

Feb 18, 1915 (Address) 123 E. Main St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.
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Where was disease contracted,
if not at place of death?

Former or
usual residence

<p>19-PLACE OF BURIAL OR REMOVAL.</p>	<p>DATE OF BURIAL.</p>
--	-------------------------------

and P. + Palmer to be: 1st July 1915

20-UNDERTAKER	ADDRESS

Van T. Hartley 2012 E. Madison

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *607 N. Montford Ave* St.; *7* WARD)

REGISTERED NO. C

86828

2-FULL NAME

(Residence in Baltimore: No. *607 N. Montford Ave* St.; — yrs., — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH

April 29, 18*49*
(Month) (Day) (Year)

7-AGE

66 yrs. *2* mos. *19* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9-BIRTHPLACE,

(State or Country),

Md

10-NAME OF FATHER,

Michael S. Garbit

11-BIRTHPLACE OF FATHER

(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Mary A. Frey rogl

13-BIRTHPLACE OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas P. Nelson
(Address) *607 N. Montford Ave*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 19, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 13, 191*5*, to *July 19*, 191*5*,that I saw him alive on *July 18*, 191*5*,and that death occurred, on the date stated above, at *1 A* m.

The CAUSE OF DEATH* was as follows:

Diphtheria
(Duration).....yrs.....mos. *21* ds.CONTRIBUTORY
(Secondary)(Signed) *Alone D. Leonard*
July 19/15, 191*5* (Address) *715 N. Patterson St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cat Lane Cemetery**July 21*, 191*5*

20-UNDERTAKER

ADDRESS

*Christian Miller**235 E. Jefferson*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

18-

JUL 19 1915

Filed

191

Baltimore Health Department
Burial Permit Clerk

Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 E. Chase ST. 7 WARD)2-FULL NAME Robert Webb Jordan(Residence in Baltimore: No. 2121 E. Chase St. 7 yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male4-COLOR OR RACE White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single6-DATE OF BIRTH May 2, 1915

(Month)

(Day)

(Year)

7-AGE 2 yrs. 17 mos. 17 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) None9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas W. Jordan11-BIRTHPLACE OF FATHER (State or Country), Md12-MAIDEN NAME OF MOTHER Catherine E. Berry13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas W. Jordan(Address) 2121 E. Chase St15- JUL 19 1915

HARRY O. ANDERSON

Filed....., 191.....

Marial Permit.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July 19, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1915, to July 19 1915, that I saw him alive on July 18 1915, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Gastric Enteritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration).....yrs.....mos.....ds.

(Signed) Edward J. Lewis M. D......, 191..... (Address) 1515 N. Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Carmel CemeteryDATE OF BURIAL, July 20, 191520-UNDERTAKER Christian MillerADDRESS 2338 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

609 W Franklin

St.

WARD)

Alice V. Brown

609 W Franklin

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH

Unknown, 1

(Month)

(Day)

(Year)

7-AGE

60

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

Gummed

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or Country)

Ind

10-NAME OF FATHER

John Coffey

11-BIRTHPLACE OF FATHER

(State or Country)

Ind

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Ireland

(Address)

609 W Franklin St

15-

Filed

191

HARRY O. ANDREWS

Chief Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 16, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Acute Cardiac Dilatation

CONTRIBUTORY (Secondary)

Organic Heart Disease

(Signed)

July 19, 1915

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery July 20, 1915

20-UNDERTAKER

ADDRESS

Christian Miller 2334 Jefferson

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 713 Hanover st. ST. 22 WARD)2-FULL NAME Julia Neuhaus

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 713 Hanover st. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED Widow
(Write the word)6-DATE OF BIRTH Dec. 23 / 1870
(Month) (Day) (Year)7-AGE 44 yrs. 7 mos. 24 ds. or min. 7 If LESS than 1 day, hrs.8-OCCUPATION (a) Trade, profession or particular kind of work Jewelry Polisher
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE (State or country) Balto. Md

PARENTS	10-NAME OF FATHER	<u>Daniel Mohr</u>
	11-BIRTHPLACE OF FATHER (State or country)	<u>Germany</u>
	12-MAIDEN NAME OF MOTHER	<u>Charlotte Dell</u>
	13-BIRTHPLACE OF MOTHER (State or country)	<u>Germany</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louise Furst
(Address) 913 Hanover St.

JUL 20 1915

Filed

191

ROBERT E. STAUTER;
Bureau Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 17/15, 1911
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 28/15, 1911, to, July 17/15, 1911,
that I saw h. or alive on July 17/15, 1911,
and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Sero-fibrinous PleuritisContributory Acute Pulmonary Edema
(SECONDARY)(Duration) yrs. mos. 19 ds.
(Duration) yrs. mos. 1 ds.
(Signed) Wm. J. M. D.
July 18/15, [Address] 933 Hanover st.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London ParkJuly 20/15

20-UNDERTAKER

ADDRESS

F.A. Krause703 Hanover

Every item of information should be carefully supplied. If not known, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86832

79

REGISTERED NO. C

2-11-68 RE
WARD

C86832

George Rung.

500 E North Street

MEDICAL CERTIFICATE OF DEATH.

6-SINGLE, *Married*
 MARRIED,
 WIDOWED,
 OR DIVORCED,
 (Write the word.)

August 13, 1841
(Month) (Day) (Year)

67 yrs 11 mos 5 ds

If LESS than 1 day,
....hrs. or....min.

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Retired.
Grocer

France.

Martin Rung

France

E Not Known

Not known

(Informant) Manuel Perez
(Address) 500 E. Ford Ave.

.....

ATH, *July*, *18th*, 19*15*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
May 20th 1915, to July 15th 1915,
 that I saw him alive on July 12th 1915,
 and that death occurred, on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH* was as follows:

Myo-Carditis

(Duration) 1 yrs. 1 mos. 1 da.

ration).....yrs.....mo.....da.
Hert Failer

..... (Duration) yrs. mos. da.
(Signed) M. D.
..... 1915. (Address)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence.....

DATE OF BURIAL,
July 21st, 1915.

ADDRESS
115 E 4th St

C86834

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86834

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1510* *Bovington* ST.; *24* WARD)

REGISTERED NO. C

2-FULL NAME

Edna A. Butschky

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1510* *Bovington* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

November 15, 1900
(Month) (Day) (Year)

7-AGE,

*14 yrs. 8 mos. 3 ds.*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None
*School child*9-BIRTHPLACE,
(State or Country).*Balto. Md.*

10-NAME OF FATHER,

*Eugene Butschky*11-BIRTHPLACE OF FATHER
(State or Country)*Balto. Co.*

12-MAIDEN NAME OF MOTHER

*Annie Pairo*13-BIRTHPLACE OF MOTHER
(State or Country).*Balto. Co.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Eugene Butschky

(Address)

1510 Bovington St.

15-

Filed

JUL 20 1915

W. KRAUTER

Baptist Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 18, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 3* 1915, to *July 18* 1915, that I saw her alive on *July 18* 1915, and that death occurred, on the date stated above, at *11:45* a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis(Duration) yrs. mos. *12* ds.CONTRIBUTORY
(Secondary)*Rheumatism (Articular)*(Duration) yrs. mos. *18* ds.

(Signed)

S. H. Street M. D.*July 18* 1915. (Address) *431 E. Lexington Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

July 20, 1915

20-UNDERTAKER

Edward L. Fanning, 1460 Battery Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618. S. Washington ST.; 40 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 618. S. Washington St.; 40 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, Married
 6-DATE OF BIRTH. Sept. 7, 1859 (Month) (Day) (Year)
 7-AGE. 56 About (yrs.) (mos.) (ds.) If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. None
 (b) General nature of industry, business, or establishment in which employed (or employer). Laborer

9-BIRTHPLACE.
 (State or Country). Germany.

10-NAME OF FATHER. Michael Weber

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Hances Gontkowski

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Weber

(Address) 618. S. Washington

15 JUL 20 1915 ROBERT E. RAUTER, Registrar

Filed....., 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19th, 1913. (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 12th 1915, to July 12th 1915, that I saw him alive on July 19th 1915, and that death occurred, on the date stated above, at 8:35 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration)..... yrs..... mos..... 7..... ds.

CONTRIBUTORY Heat Prostration (Secondary)

(Duration)..... yrs..... mos..... 1..... ds.

(Signed) Jacob L. Winner M. D.

7-1-1915, 1915. (Address) 30 S. B'way

*State the DISEASE CAUSING DEATH, or, in deaths from Violent Causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary DATE OF BURIAL, July 21, 1915

20-UNDERTAKER William Gontkowski ADDRESS 1618 Eastern Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.: *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Inf. Asylum* St.: yrs. / mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

June 17th, 1914
(Month) (Day) (Year)

7-AGE,

*1 mos. 2 ds.*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15 JUL 20 1915

ROBERT E. ERSTER

Filed *101* *Special Death Clerk* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 19, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1st 1915*, to *July 19 1915*, that I saw her alive on *July 19 1915*, and that death occurred, on the date stated above, at *3:30 P.m.* The CAUSE OF DEATH* was as follows:*Malnutrition and Malassimilation*

(Duration) yrs. / mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. / mos. ds.

(Signed) *J. P. Sullivan* M. D.*July 19, 1915* (Address) *615 Columbia*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. / mos. ds. In the State yrs. / mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral *July 20 1915*

20-UNDERTAKER

ADDRESS

W. F. Kelly & Sons 606 Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly examined. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86837

C86837

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1306 Stockton*)

ST. *15* WARD)

FULL NAME

Joseph Osborn Middleblain

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

(Residence in Baltimore: No. *1306 Stockton*)

St.; yrs. *2* mos. *16* ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX *Male* COLOR OR RACE *Chd.* SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

DATE OF BIRTH *May 3, 1915* (Month) (Day) (Year)

AGE *2* yrs. *16* mos. *16* ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work *None* (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country) *Baltimore*

PARENTS 10. NAME OF FATHER *John Middleblain*

11. BIRTHPLACE OF FATHER (State or country) *Maryland*

12. MAIDEN NAME OF MOTHER *Sarah Syson*

13. BIRTHPLACE OF MOTHER (State or country) *Maryland*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Sarah Middleblain*

(Address) *1306 Stockton St.*

15. JUL 20 1915 *JOSEPH A. KRAUTER, Registrar*

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *July 19, 1915* (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *July 14, 1915* to *July 19, 1915* that I saw him alive on *July 19, 1915* and that death occurred, on the date stated above, at *2 A.* m. The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Contributory (SECONDARY) *Asphyxia* (Duration) yrs. *4* mos. *4* ds.

(Signed) *T. E. Daugherty* M. D. (Address) *1602 Penna. Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *St. Auburn* DATE OF BURIAL *July 30, 1915*

20. UNDERTAKER *James H. Dennis* ADDRESS *1303 Preston*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86839

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital* 41
 CITY OF BALTIMORE: (No. *Lombard & Greene* 15) WARD
 2-FULL NAME *William Ward*
 (Residence in Baltimore: No. *3000 Grayson St. (Walbrook)* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married*
 (Write the word.)
 6-DATE OF BIRTH, *unknown*, 18*55*
 (Month) (Day) (Year)

7-AGE, *60* yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, *Painter*
 (b) General nature of industry, business, or establishment in which employed (or employer), *House & sign*

9-BIRTHPLACE, (State or Country) *Ind.*

PARENTS.
 10-NAME OF FATHER, *Mr. Y. Ward*
 11-BIRTHPLACE OF FATHER (State or Country), *Maryland*
 12-MAIDEN NAME OF MOTHER, *Jenny Ward*
 13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Y. Ward*
 (Address) *3000 N. Grace St. Walbrook*

15- *WALBROOK*
 JUL 20 1915
 REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July - 19 -*, 1915
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 23* 1915, to *July 19* 1915, that I saw him alive on *July 19* 1915, and that death occurred, on the date stated above, at *8 P. M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach and Liver
 (Duration) *2 yrs. 6 mos. ds.*

CONTRIBUTORY *As above*
 (Secondary)

(Signed) *M. H. Schickel* M. D.
July 19, 1915 (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. *26* ds. In the State *60* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *3000 N. Grace St. Walbrook*

19-PLACE OF BURIAL OR REMOVAL, *Landon Park* DATE OF BURIAL, *July 22, 1915*

20-UNDERTAKER, *Wm. Cook* ADDRESS, *Walbrook*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. 2539 Frederick Ave ST. 20 WARD)

FULL NAME Robert L. Mason, Jr

(Residence in Baltimore: No. 2539 Frederick Ave St. yrs. 8 mos. 3 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6-DATE OF BIRTH July 19, 1915
(Month) (Day) (Year)

7-AGE 8 yrs. 3 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
None

9-BIRTHPLACE (State or country)
Baltimore Md

PARENTS
10-NAME OF FATHER Robert L. Mason
11-BIRTHPLACE OF FATHER (State or country) Baltimore Md
12-MAIDEN NAME OF MOTHER Anna M. Whalen
13-BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert L. Mason
(Address) 2539 Frederick Ave

15-JUL 20 1915
Filed ROBERT L. KRAUTER
Municipal Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19, 1915, to July 19, 1915, that I saw him alive on July 19, 1915, and that death occurred, on the date stated above, at 12:15 P.m. The CAUSE OF DEATH* was as follows:

Diarrhea and Enteritis

(Duration) yrs. mos. ds.
Contributory (SECONDARY) Hot weather
(Duration) yrs. mos. ds.

(Signed) Asa J. Bessels M. D.
July 20, 1915 (Address) 2545 Fred. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Roaden Park Cem DATE OF BURIAL July 20, 1915
20-UNDERTAKER Joseph J. Cook ADDRESS 1003 W. Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1815 Eastern Ave. ST.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Louis Langrecher(Residence in Baltimore: No. 1815 Eastern Ave. St.; 43 yrs. 10 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH,

Sept. 1st, 1860
(Month) (Day) (Year)

7-AGE,

54 yrs. 10 mos. 18 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired Laborer

9-BIRTHPLACE, (State or Country),

California

10-NAME OF FATHER,

John Langrecher

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Waburga Staub

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Langrecher(Address) 1815 Eastern Ave.

15- JUL 20 1915

Filed

ROBERT KRIETER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, 18, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 29 1913, to July 18 1915, that I saw him alive on July 18 1915, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage
Atherosclerosis(Duration) 2 yrs. 7 mos. 7 ds.CONTRIBUTORY (Secondary) Central Hemorrhage(Duration) 7 yrs. 7 mos. 7 ds.(Signed) E. H. Miller M. D.7-19..., 1915. (Address) 1937 Gough St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. 10 mos. 18 ds. In the State 43 yrs. 10 mos. 18 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn

DATE OF BURIAL,

July 21, 1915

ADDRESS

4038 Wolfe St.

20-UNDERTAKER

Lilly & Zeiler

CAUSE OF DEATH in plain terms, so that it may be properly understood. Exact statement of occupation is very important. See instructions on back of certificate.

C86842 HEALTH DEPARTMENT—CITY OF BALTIMORE

C86842

CERTIFICATE OF DEATH.

113 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3021 Eastern Ave. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 3021 Eastern Ave. 41 yrs., 1 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH

June 9, 1874
(Month) (Day) (Year)

7-AGE

41 yrs., 1 mos., 9 ds.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Clerk in Bakery

9-BIRTHPLACE, (State or Country),

Baltimore Md.

10-NAME OF FATHER,

Richard Vieschon

11-BIRTHPLACE OF FATHER, (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Mary M. Thill

13-BIRTHPLACE OF MOTHER, (State or Country),

Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Frances E. Vieschon

(Address)

3021 Eastern Ave.

15-

JUL 20 1915

Filed.

HEART. KRAUTER,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July - 18, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 25th 1915, to July 18 1915, that I saw him alive on July 18 1915, and that death occurred, on the date stated above, at 9:40 AM.

The CAUSE OF DEATH* was as follows:

Sclerosis of Liver

(Duration) yrs. one mos. 23 ds.

CONTRIBUTORY, (Secondary)

(Duration) yrs. mos. ds.

(Signed)

F. B. Link M. D.
July 18, 1915 (Address) 1313 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral C.

DATE OF BURIAL,

July 21, 1915

ADDRESS

4038 Rogers St.

20-UNDERTAKER

Lilly & Zule

CASE OF DEATH IN plain terms, so that it may be properly translated. Exact statement of OCCUPATION very important. See instructions on back of certificate.

C86843

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

St.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-JUL 20 1915,

ROBERT KRAUTER,
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C8684

HEALTH DEPARTMENT—CITY OF BALTIMORE

C8684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

St.

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUL 20 1915

ROBERT KRAUTER,

Special Permit Clerk,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said inquest, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull (Accident) fall from 2nd story window

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDE, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence,

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS,

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Mrs. Gen. Hosp't. 14

REGISTERED NO. C

2-FULL NAME

Maud Johnson

(Residence in Baltimore: No.

1737 Druid Hill Ave.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

April 18, 1915

7-AGE.

3 yrs. 3 mos. 1 ds.

IF LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country).

Baltimore

10-NAME OF FATHER.

Wm. Johnson

11-BIRTHPLACE OF FATHER (State or Country).

Md.

12-MAIDEN NAME OF MOTHER

Maud Johnson

13-BIRTHPLACE OF MOTHER (State or Country).

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm. N. Johnson

(Address)

1737 Druid Hill Ave.

15-

JUL 20 1915

B. KRAUTER

S. M. 121. PARKS CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 19, 1915

17- I HEREBY CERTIFY, That I attended deceased from July 16, 1915, to July 19, 1915, that I saw her alive on July 19, 1915, and that death occurred, on the date stated above, at 2:15 A.M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

CONTRIBUTORY (Secondary)

(Signed) J. P. Patton M. D.
July 19, 1915 (Address) 615 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. 3 mos. 1 ds. In the State yrs. 3 mos. 1 ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 1737 Druid Hill Ave.

19-PLACE OF BURIAL OR REMOVAL.

Mt. Auburn

DATE OF BURIAL.

July 20, 1915

20-UNDERTAKER.

Sam'l. T. Hensley

ADDRESS

578 W. Bedle

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 Mulliken St.; 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1217 Mulliken St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widow (Write the word.)6-DATE OF BIRTH, February 18, 1868 (Month) (Day) (Year)7-AGE, 47 yrs. - mos. - ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housework (b) General nature of industry, business, or establishment in which employed (or employer), Private Family9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, Levi's Stewart11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER, Sue M. Glover13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Jenkins(Address) 14417 Ward St

15-ROBERT K. KROGER, Registrar.

Filed JUL 20 1915 Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19, 1915 (Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from April 10, 1915 to July 19, 1915, that I saw him alive on July 18, 1915, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Maternal decomposition
General debility
(Duration) yrs. mos. ds.CONTRIBUTORY Acute nephritis (Secondary)
(Duration) yrs. mos. ds.(Signed) J. P. Robinson M. D.
July 19, 1915 (Address) 611 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. AuburnDATE OF BURIAL, 7/20, 191520-UNDERTAKER, Sam'l L. KumbayADDRESS, 578 N. Bridge

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1429 N. Mount* ST.; *15* WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Eraline Neal*(Residence in Baltimore: No. *1429 N. Mount* St.; *4* yrs., *4* mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

April 18, 1915
(Month) (Day) (Year)

7-AGE,

3
4 yrs., *4* mos., *4* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Md.*

10-NAME OF FATHER,

*Robert Neal*11-BIRTHPLACE OF FATHER
(State or Country),*Md.*

12-MAIDEN NAME OF MOTHER

*Priscilla Quinn*13-BIRTHPLACE OF MOTHER
(State or Country),*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert Neal
(Address) *1429 N. Mount*

15-

JUL 20 1915

Filed

ROBERT KRIEGER, Mortuary

Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 18, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 17, 1915*, to *July 17, 1915*, that I saw him alive on *July 17, 1915*, and that death occurred, on the date stated above, at *6:00 a.m.*

The CAUSE OF DEATH* was as follows:

Gastric Enteritis
(Duration) *2* yrs., *4* mos., *4* ds.CONTRIBUTORY
(Secondary)(Duration) *2* yrs., *4* mos., *4* ds.(Signed) *John D. Quinn, M. D.**July 17, 1915* (Address) *1507 N. Fulton Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *4* yrs., *4* mos., *4* ds. In the State *4* yrs., *4* mos., *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Mount Auburn**July 20, 1915*

20-UNDERTAKER

ADDRESS

*John H. Owens**1222 Avenue*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4186-26th St.*)

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Peter Kennedy.*(Residence in Baltimore: No. *4186-26th St.*)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

March 13th, 1854
(Month) (Day) (Year)

7-AGE,

61 yrs. 4 mos. 6 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Foreman Engine Shop

9-BIRTHPLACE, (State or Country),

Ind.

10-NAME OF FATHER,

Martin Kennedy.

11-BIRTHPLACE OF FATHER (State or Country),

Ireland.

12-MAIDEN NAME OF MOTHER

Margaret Bellwood

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE:

(Informant) *Margaret Kennedy.*(Address) *418 26th St.*

15-

JUL 20 1915

Filed

191

ROBERT KRAUTER

SPECIAL REGISTRAR

Registrar.

16-DATE OF DEATH,

July 18th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 26th, 1914, to *July 18th, 1915*,

that I saw him alive on

July 18th, 1915,and that death occurred, on the date stated above, at *8.25 AM*

The CAUSE OF DEATH* was as follows:

*Mitral Regurgitation
Dilatation of Left
Ventricle*
(Duration) yrs. *13* mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Geo. H. Mergatroyd M.D.**July 18th, 1915* (Address) *3537 Frederick Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*New Cathedral Cemetery**July 22 1915*

20-UNDERTAKER

ADDRESS

*George J. Ruth**1735 Harford Ave.*

CROSS OF DEATH in print form, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86849

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2524 Ashland Ave* St.; *7* WARD)2-FULL NAME *Thomas H. Malone*(Residence in Baltimore: No. *2524 Ashland Ave* St.; *7* yrs., *2* mos., *2* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

*May 6**1846*

(Month)

(Day)

(Year)

7-AGE,

*69**W**3**ds.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Farmer

9-BIRTHPLACE,

(State or Country),

Ireland

10-NAME OF FATHER,

James Malone

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Eliza Finnegan

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Elizabeth C. Malone

(Address)

2524 Ashland Ave

15 JUL 20 1915

ROBERT A. KAUFER

Filed....., 1915

Capital Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July 19**1915*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 15 1915, to *July 19* 1915,that I saw him alive on *July 19* 1915,and that death occurred, on the date stated above, at *630 P.M.*

The CAUSE OF DEATH* was as follows:

*Broncho pneumonia**(General and Cerebral)*(Duration)..... yrs..... mos..... *2* ds.CONTRIBUTORY *Arterio-sclerosis*(Secondary) *of indeterminate* (Duration)..... yrs..... mos..... ds.(Signed)..... *E. S. Hayward*..... M. D.*7/19*....., 1915. (Address) *53 E. E. T. St. S. W. 12*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cambridge, Md.**July 20*, 1915

20-UNDERTAKER

ADDRESS

*William Cook**52 E. N. St.*

Important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *Pronounced dead at Mercy Hospital*)
2-FULL NAME *Louis Miller*
(Residence in Baltimore: No. *127 S. Anne St.*)

174
2
WARD

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *8* mos. *6* ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)
6-DATE OF BIRTH, *Undocumented*
(Month) (Day) (Year)
7-AGE, *8* yrs. *6* mos. *6* ds.
IF LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Child*
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), *City*
10-NAME OF FATHER, *Morris Miller*
11-BIRTHPLACE OF FATHER (State or Country), *Russia*
12-MAIDEN NAME OF MOTHER *Ester Stein*
13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Ester Miller*
(Address) *127 S. Anne St.*

15- *JUL 20 1915* *JOSEPH KRAUTER,*
Filed, 191 *Suppl. Death Clerk*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 19, 1915*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said *Inquiry*
(Inquest, autopsy or inquiry.)
and that said deceased came to *Death*
on the day stated above.
The CAUSE OF DEATH* was as follows:
Accident - Crushed in freight elevator shock.
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) *H. P. Chambers* M. D.
(Coroner.)
July 20 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, *John Mt. Carmel*
20-UNDERTAKER, *S. Lincoln & Co.*
DATE OF BURIAL, *July 20 1915*
ADDRESS, *1107 E*

C86851

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86851

CERTIFICATE OF DEATH.

28

PLACE OF DEATH

CITY OF BALTIMORE: (No. *902 Ramsey St.* ST. *21* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

3-FULL NAME *Catherine Morrison*(Residence in Baltimore: No. *902 Ramsey*

St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, *married*,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Unknown, 1886

(Month)

(Day)

(Year)

7-AGE.

29

yrs., mos., ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housewife*9-BIRTHPLACE,
(State or Country).*Maryland.*

10-NAME OF FATHER

Pat. Shattery

11-BIRTHPLACE OF FATHER

(State or Country).

Ireland.

12-MAIDEN NAME OF MOTHER

Margaret Timothy

13-BIRTHPLACE OF MOTHER

(State or Country).

Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry B. Ramsey*(Address) *902 Ramsey St.*

15-

File

JUL 20 1915

191

*Harry B. Ramsey**Marial Parale. Q. 10*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July

(Month)

19, 1915

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Nov 21* 191*4*, to *July 18* 191*5*, that I saw her alive on *July 15* 191*5*, and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

Pneumonia fulminans(Duration) *4* yrs., *1* mos., *1* da.CONTRIBUTORY
(Secondary)(Duration) *4* yrs., *1* mos., *1* da.(Signed) *E. E. Connelley, Coroner**July 20 1915* (Address) *Municipal H. Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *2* yrs., *8* mos., *1* da. In the State *28* yrs., *8* mos., *1* da.Where was disease contracted, if not at place of death? *unknown*Former or usual residence *902 Ramsey St.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cathedral Cemetery**July 22, 1915*

20-UNDERTAKER

ADDRESS

John Roman & Co 901 Hollis St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *34 W. Cross St.*)

2-FULL NAME

(Residence in Baltimore: No. *34 W. Cross St.*)

REGISTERED No. C

ST.: *23* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *7* yrs., *1* mos., *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-JUL 20 1915.

Filed *1915* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed) *Edw. G. Smith* M. D.
(Coroner.)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *114* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Alba Terrace Hamilton md* St. *114* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)

6-DATE OF BIRTH, *Unknown, 1847*
(Month) (Day) (Year)

7-AGE, *68* yrs. *—* mos. *—* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *House work*
(b) General nature of industry, business, or establishment in which employed (or employer), *Retired*

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *John Rauch*

11-BIRTHPLACE OF FATHER (State or Country), *Ga*

12-MAIDEN NAME OF MOTHER, *Mary Denhardt*

13-BIRTHPLACE OF MOTHER (State or Country), *Ga*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Cornell*(Address) *Hamilton Md*

15-

JUL 20 1915

HARRY O. ANDREWS

Filed 1915

Special Permit 014

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 20, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended decedent from *July 19, 1915*, to *July 20, 1915*, that I saw her alive on *July 20, 1915*, and that death occurred, on the date stated above, at *11-20 a.m.*
The CAUSE OF DEATH* was as follows: *Empyema of Gall bladder*

(Duration) *6* yrs. *—* mos. *—* ds.
CONTRIBUTORY (Secondary) *Cholitis*

(Duration) *3* yrs. *—* mos. *—* ds.
(Signed) *R. L. Johnson* M. D.
July 20, 1915 (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *—* mos. *—* ds. Is the State *68* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death? *Hamilton*Former or usual residence *md*19-PLACE OF BURIAL OR REMOVAL, *London Park*DATE OF BURIAL, *July 23, 1915*20-UNDERTAKER, *Martin Fayerdous*ADDRESS, *606 Lafayette Ave*

CAUSE OF DEATH is printed in plain type so that it may be properly classified. Each statement on back of certificate is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *Provenance dead at Mercy Hospital* St. *3* WARD)

2-FULL NAME

Theodore Stockett

(Residence in Baltimore: No.

514 N. Spring St.

St. yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

December 31, 1901
(Month) (Day) (Year)

7-AGE.

13 yrs. *6* mos. *19* ds.

IF LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9-BIRTHPLACE.

(State or Country).

Nat.

10-NAME OF FATHER.

Edward Stockett

11-BIRTHPLACE OF FATHER

(State or Country).

Nat.

12-MAIDEN NAME OF MOTHER

Lillie Stockett

13-BIRTHPLACE OF MOTHER

(State or Country).

Nat.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lillie Stockett

(Address)

514 N. Spring St.

JUL 20 1915.

Filed..... 191.

Marial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to *his* death (Inquest, au-
topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident - Drowned while swimming in Harbor off Pier #4 Pratt St.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Thos. H. Chambers* M. D.
(Coroner.)

July 20, 1915 (Address) *18 N. Frederick St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Asbury Cemetery July 22, 1915

20-UNDERTAKER

ADDRESS

Wm. Gross 1405 McElderry St.

N.B.—Every item of information should be externally supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2724 for Charles ST.: 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. 3432 Eastern ave St.: 30 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Chinese

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH,

Unknown, 1871
(Month) (Day) (Year)

7-AGE,

44

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laundress

9-BIRTHPLACE, (State or Country),

China

10-NAME OF FATHER,

Jung On

11-BIRTHPLACE OF FATHER (State or Country),

China

12-MAIDEN NAME OF MOTHER

Moun Shu

13-BIRTHPLACE OF MOTHER (State or Country),

China

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jung G. Chung, Jr.(Address) 3432 Eastern Ave

15- JUL 20 1915

Filed..... 1915.....
HARRY C. ANDREWS,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 18 1915, to July 19 1915,
that I saw him alive on July 19 1915,
and that death occurred, on the date stated above, at KA m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. — mos. — ds.(Signed) J. C. Andrews M. D......, 1915 (Address) 3432 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. — mos. — ds. In the State — yrs. — mos. — ds.Where was disease contracted, if not at place of death? 3432 Eastern AveFormer or usual residence 3432 Eastern Ave

19-PLACE OF BURIAL OR REMOVAL,

Balto. Cemetery

DATE OF BURIAL,

July 25, 1915

20-UNDERTAKER

E. W. Mitchell

ADDRESS

1201 W. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

C86853

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1)

2-FULL NAME

(Residence in Baltimore: No. 10 S. Bethel

Franklin Sq. Nos. 3
Edward Merrill
10 S. Bethel

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

male

4-COLOR OR RACE.

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

widowed

6-DATE OF BIRTH.

unknown, 1
(Month) (Day) (Year)

7-AGE.

39

yrs. mos. ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Labourer,
Cement Factory

9-BIRTHPLACE.

(State or Country),

unknown

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER (State or Country).

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Lena Merrill
10 S. Bethel St.

15-

Filed

JUL 20 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 20, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12, 1915, to July 20, 1915, that I saw him alive on July 20, 1915, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuber-
culosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. E. Sneed, M. D.

191... (Address) Franklin Sq. 3

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 8 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 10 S Bethel St.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL

Arbury Cem July 21, 1915

20-UNDERTAKER

ADDRESS

Harry Andrews 1725 Dr

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *754 W. Fayette* ST.; *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *& Infant of Mary Dixon*(Residence in Baltimore: No. *754 W. Fayette* St.; yrs., mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) *single*6-DATE OF BIRTH, *July 17*, 1915

(Month)

(Day)

(Year)

7-AGE, yrs., mos., *4* ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Maryland (City)*10-NAME OF FATHER, *Harry Miller*11-BIRTHPLACE OF FATHER (State or Country), *Not known*12-MAIDEN NAME OF MOTHER *Dixon*13-BIRTHPLACE OF MOTHER (State or Country), *S. Carolina*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Gertrude Katzen*(Address) *754 W. Fayette*

15-

JUL 20 1915

HARRY O. ANDREWS,

Filed 191. *Serial Permit* *Oliver's* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 20*, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 18* 1915, to *July 20* 1915, that I saw her alive on *July 18* 1915, and that death occurred, on the date stated above, at *5 a. m.*

The CAUSE OF DEATH* was as follows:

Premature birth, about 7-8 months unable to nurse
(Duration) yrs., mos., *3* ds.

CONTRIBUTORY (Secondary).....

(Duration) yrs., mos., ds.

(Signed) *Harry Miller* *Seidel* M. D.*July* 191... (Address) *1523 E. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Schwartz Cem*DATE OF BURIAL, *July 21*, 191520-UNDERTAKER *Mr & Mrs Geo W. Seufel*ADDRESS *501 W. Fayette*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 Furrow ST.; 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Richter(Residence in Baltimore: No. 413 Furrow StSt.:yrs., 2 mon. 3 ds)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX, Female4-COLOR OR RACE, White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, May 16, 1915

(Month)

(Day)

(Year)

7-AGE, 2 3

yrs. mon. ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ind (City)10-NAME OF FATHER, Christian Richter11-BIRTHPLACE OF FATHER (State or Country), Balt.12-MAIDEN NAME OF MOTHER, Marguerite Paul13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christian Richter(Address) 413 Furrow St.

15-

JUL 20 1915

HARRY O. ANDERSON,

Filed..... 191. MARIAL. PERMIT. CLARK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1915, to July 19, 1915, that I saw h... alive on July 17, 1915, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion Saturated
stomach (Duration) yrs. mos. 2 ds.CONTRIBUTORY (Secondary) Intoxication(Duration) yrs. mos. 21 ds.(Signed) Herbert K. ... M. D.July 19, 1915 (Address) 2027 Q. Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Claret Cem.DATE OF BURIAL, July 21, 191520-UNDERTAKER, Charles W. HillADDRESS 3109Frank Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86859

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

105 C86859
REGISTERED No. C

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 721 E. 41st St. 9 WARD)

2. FULL NAME

William Parker Hall

(Residence in Baltimore: No. 721 E. 41st St.)

Str.: — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6. DATE OF BIRTH May 16, 1832 (Month) (Day) (Year)

7. AGE 83 yrs. 2 mos. 3 ds. If LESS than 1 day, — hrs. or — min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Shoe Maker
Cobbler

9. BIRTHPLACE (State or country)

Va.

PARENTS

10. NAME OF FATHER

James C. Hall

11. BIRTHPLACE OF FATHER (State or country)

Va.

12. MAIDEN NAME OF MOTHER

Ann Cox

13. BIRTHPLACE OF MOTHER (State or country)

Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. H. Hall

(Address)

721 E. 41st St.

JUL 20 1915

HARRY O. ANDREWS,
Morial Permit Clerk

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 19th, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1915, to July 19, 1915, that I saw him alive on July 18, 1915, and that death occurred, on the date stated above, at 6 a. m. The CAUSE OF DEATH* was as follows:

Gastro-enteritis

Contributory (SECONDARY)

(Duration) 5 yrs. 5 mos. 5 ds.

(Signed)

July 19, 1915 (Address) 507 Franklin Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Baltimore Cemetery July 21, 1915

20. UNDERTAKER

ADDRESS

Horace Burge 1631 Fell's Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Beverie J. Mackle*(Residence in Baltimore: No. *University Hospital* St.; *2* yrs., *7* mos., *23* ds.)
Bryantown Md.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*Colored*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Married*

6-DATE OF BIRTH.

Unknown, 1891
(Month) (Day) (Year)

7-AGE,

24 yrs. *—* mos. *—* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housewife*9-BIRTHPLACE,
(State or Country),*Maryland*

PARENTS.

10-NAME OF FATHER,

*Joe Johnson*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*B. Penn*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Hospital Records

(Address).....

15 JUL 20 1915.

HARRY O. ANDERS,

Filed..... 191.. *Serial Permit* *Oliver*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, 20, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 27*, 1915, to *July 20*, 1915, that I saw her alive on *July 20*, 1915, and that death occurred, on the date stated above, at *7:45 a.m.*

The CAUSE OF DEATH* was as follows:

*Cardiac Asthenia*CONTRIBUTORY (Secondary) *Arteriosclerosis*
(Duration)..... yrs. *24* mos. *—* ds.(Signed) *R. L. Johnson* M. D.*July 20*, 1915. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. *2* mos. *23* ds. In the *24* yrs. *—* mos. *—* ds.Where was disease contracted, if not at place of death? *Bryantown, Md.*Former or usual residence *Bryantown Md.*

19-PLACE OF BURIAL OR REMOVAL,

Bryantown Md. *July 21*, 1915.

20-UNDERTAKER

Ex B Harle

ADDRESS

115 E West St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *Wm* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Johns Hopkins Hospital* St. *—* yrs. *—* mos. *8* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *married*

6-DATE OF BIRTH.

November 6, *1877*.
(Month) (Day) (Year)

7-AGE.

43 yrs. *7* mos. *13* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country).

Georgia

10-NAME OF FATHER.

J. M. Dawson

11-BIRTHPLACE OF FATHER (State or Country).

Georgia

12-MAIDEN NAME OF MOTHER

Sara Snodgrass

13-BIRTHPLACE OF MOTHER (State or Country).

Alabama

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. J. Smith*(Address) *Johns Hopkins Hospital*

15-

JUL 20 1915 *HARRY O. ANDERSON*
Filed *July 20* 1915 *Marial. Permit. 0107*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 20, *1915*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 12, *1915*, to *July 20*, *1915*.that I saw her alive on *July 20*, *1915*.and that death occurred, on the date stated above, at *5:20 P.* m.

The CAUSE OF DEATH* was as follows:

Chronic Myeloid Leukaemia(Duration) *2* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.(Signed) *G. Guthrie* M. D.*July 20, 1915* (Address) *Johns Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *8* yrs. *—* mos. *—* ds. In the *—* State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Cordelle Ga

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Cordelle Ga**July 20, 1915*

20-UNDERTAKER

ADDRESS

*Ellis C. Fuller**221 N. Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 832 N. Butaw street,

2-FULL NAME William Harry Pierson,

(Residence in Baltimore: No. 832 N. Butaw street,

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 1 mos. 14 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male,

4-COLOR OR RACE,

White,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single,

6-DATE OF BIRTH,

September 21st, 1875.

7-AGE,

39 yrs., 9 mos., 29 da.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Architect.

9-BIRTHPLACE,

(State or Country),

Wilmington, Delaware,

10-NAME OF FATHER,

William H. Pierson,

11-BIRTHPLACE OF FATHER

(State or Country), Wilmington, Del.

12-MAIDEN NAME OF MOTHER

Milanda Hendrix,

13-BIRTHPLACE OF MOTHER

(State or Country), Wilmington, Del.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank W. Pierson, brother,

(Address) Wilmington, Delaware.

15-

JUL 20 1915.

HARVEY O. ANDREWS,

Filed..... 191..... Marial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 20th, 1915.

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laryngeal tuberculosis.

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Signed) J. Frederick Kempel M. D.

July 20, 1915. (Address) 3310 N. North av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. 1 mos. 14 da. In the State... yrs. mos. da.

Where was disease contracted, if not at place of death? Alexandria, Va.

Former or usual residence Alexandria, Va.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Wilmington Delaware July 21, 1915.

20-UNDERTAKER

J. M. Lawther

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (NO. *Barton Hollow* ST. *1* WARD) REGISTERED NO. C
2-FULL NAME *Joseph Dembus*
(Residence in Baltimore: No. *Chester, Penna.* St. *1* yrs. *—* mos. *—* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)
6-DATE OF BIRTH, *Not known*, *1*
(Month) (Day) (Year)

7-AGE, *35* yrs. *—* mos. *—* da. If LESS than 1 day, *—* hrs. or *—* min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer), *Castore's Drapery Co.*

9-BIRTHPLACE.
(State or Country), *Russia*

PARENTS.
10-NAME OF FATHER, *Not known*
11-BIRTHPLACE OF FATHER (State or Country), *Not known*
12-MAIDEN NAME OF MOTHER, *Not known*
13-BIRTHPLACE OF MOTHER (State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Elizabeth Dembus*
(Address) *Chester, Penna.*

15-*ROBERT KRAUTER*
JUL 21 1915, *Special Permit Clerk*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 18*, 191*5*.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) *—* yrs. *—* mos. *—* da.

CONTRIBUTORY
(Secondary)

(Duration) *—* yrs. *—* mos. *—* da.

(Signed) *D. W. Jones* M. D.
(Coroner.)

July 20, 191*5* (Address) *3415 34th Street*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *—* In the *—*
of death *—* yrs. *—* mos. *—* da. State *—* yrs. *—* mos. *—* da.

Where was disease contracted, if not at place of death? *—*

Former or usual residence *—*

19-PLACE OF BURIAL OR REMOVAL, *Chester Pa* DATE OF BURIAL, *July 21*, 191*5*

20-UNDERTAKER, *William Cook* ADDRESS *504 E. 7th St.*

Every item of information should be carefully reported. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *1612 Gathole*) ST. *12* WARD
FULL NAME *Annie Adell Johnson*
(Residence in Baltimore: No. *1612 Gathole*) St.; yrs., mos., ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *Colored* 5-~~MARRIED~~ *Married*
6-DATE OF BIRTH, *July 1*
(Month) (Day) (Year)

7-AGE, *22* yrs., mos., ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Harford Co., Md.*

10-NAME OF FATHER, *George Cox*

11-BIRTHPLACE OF FATHER (State or Country), *Harford Co., Md.*

12-MAIDEN NAME OF MOTHER, *Sarah Benson*

13-BIRTHPLACE OF MOTHER (State or Country), *Harford Co., Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. Johnson (Husband)*
(Address) *1612 Gathole St.*

15- *JUL 21 1915* *DAVID CLARK*
Filed, 191. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 18, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pericarditis - Acute

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *and Pleurisy*

(Duration) yrs. mos. ds.

(Signed) *W. B. Chambers* M. D. (Coroner.)

July 19, 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Laurel cemetery* DATE OF BURIAL, *July 21, 1915*

20-UNDERTAKER *Felix B. Tye* ADDRESS *102 E. Mulberry St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *German & Orleans St.*
 CITY OF BALTIMORE: (No. *German & Orleans St.* WARD) *5*
 2-FULL NAME *Bertha L. Herrmann*
 (Residence in Baltimore: No. *410 N. Duncan* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
 6-DATE OF BIRTH, *Dec 16, 1907*
 (Month) (Day) (Year)
 7-AGE, *7 yrs. 7 mos. 4 ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, *George W. Herrmann*
 11-BIRTHPLACE OF FATHER (State or Country), *Ind*
 12-MAIDEN NAME OF MOTHER *Matilda Kossman*
 13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Matilda Herrmann*
 (Address) *410 N. Duncan St.*

15- JUL 21 1915

Filed..... 191.....

ROBERT KRAUTER

Surgeon General

Registrar.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 20 - 1915
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 10* 1915, to *July 20* 1915, that I saw her alive on *July 19* 1915, and that death occurred, on the date stated above, at *99* m.

The CAUSE OF DEATH was as follows:

Pneumonia
following Measles
 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Scarlet fever
 (Duration) yrs. mos. ds.
 (Signed) *W. H. Brown* M. D.
July 20, 1915 (Address) *125 N. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. mos. ds. In the *apt* State *Ind* yrs. mos. ds.

Where was disease contracted, if not at place of death? *410 N. Duncan*

Former or usual residence *410 N. Duncan*

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn

20-UNDERTAKER

H. Sanderland

DATE OF BURIAL,

July 21 1915

ADDRESS

1748 E. ... St.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2629 Eastern Ave* ST. *1* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2629 Eastern Ave* St. *1st* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Widowed

6-DATE OF BIRTH,

April 29th 1858
(Month) (Day) (Year)

7-AGE,

59 yrs. 2 mos. 19 ds.

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE,

(State or Country).

Baltimore Md.

10-NAME OF FATHER,

Joseph Lee

11-BIRTHPLACE OF FATHER

(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Mary R. Townsend

13-BIRTHPLACE OF MOTHER

(State or Country).

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Richard Sullens

(Address)

2629 Eastern Ave

15-

JUL 21 1915

Filed

191

W. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 18, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 1913 to *July 1915*that I saw him alive on *July 18* 1915and that death occurred, on the date stated above, at *10:45 p.m.*

The CAUSE OF DEATH* was as follows:

Chronic degenerative disease of the heart
*Carcinoma of the uterus**About* (Duration) *3* yrs. *1* mo. *19* ds.CONTRIBUTORY (Secondary) *Carcinoma of the uterus**About* (Duration) *3* yrs. *1* mo. *19* ds.(Signed) *L. R. P. M. D.**July 18 1915* (Address) *1000 ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Mount Carmel Cem.**July 21, 1915*

20-UNDERTAKER,

ADDRESS

*A. Sander Sons**1700 Fleet St.*

important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

79
REGISTERED NO. C

CITY OF BALTIMORE: (No. 1020 N. Fulton Ave. 16)

WARD)

2-FULL NAME

Bulah Benson

(If death occurred in a hospital or institution, give its NAME instead of street and number and file No. 18.)

(Residence in Baltimore: No. 1020 N. Fulton Ave.

St. 37 yrs. 4 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

APPROVED

(OR DIVORCED)

(Write the word)

6-DATE OF BIRTH

Feb 24 1878
(Month) (Day) (Year)

7-AGE

37 4 26
yrs. mos. ds. or min.?

If LESS than

1 day, hrs.,

or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Baltimore Md.

10-NAME OF FATHER

Martin K. Benson

11-BIRTHPLACE OF FATHER
(State or country)

West Va. Md.

12-MAIDEN NAME OF MOTHER

Emma K. Cassell

13-BIRTHPLACE OF MOTHER
(State or country)

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Mrs. Emma K. Benson
(Informant)

(Address) 1020 N. Fulton Ave.

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

July 20 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Dec 26 1914, to July 20 1915,

that I saw him alive on July 19 1915,

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

Contributory
(SECONDARY)

Bright's disease 6 years

(Signed) Elmer B. S. Vogler M. D.

July 20 1915 [Address] Hamilton Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Corraine Cemetery July 23 1915

20-UNDERTAKER

ADDRESS

George Smith Fayette St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 21 1915

ROBERT KRAUTER

Burial Permit Clerk

REGISTRAR

Filed

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1. PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

2. FULL NAME

(Residence in Baltimore: No.

St.:

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH

7. AGE

If LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. JUL 21 1915

Filed

191

ROBERT KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

June 28, 1915, to July 19, 1915,

that I saw him alive on July 18, 1915,

and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contributory (SECONDARY)

(Signed),

July 21, 1915. (Address) 1118 Bond Street, Baltimore, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union Bethel

July 21, 1915

20. UNDERTAKER

ADDRESS

Samuel J. Henry

578 W. Biddle St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1904 Duvid Hill Ave.* St. *14* WARD)

2-FULL NAME *Elizabeth Colcock*

(Residence in Baltimore: No. *1904 Duvid Hill Ave.* St.; yrs. mos. ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*

4-COLOR OR RACE *Colored*

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) *Widow*

6-DATE OF BIRTH

Unknown.
(Month) (Day) *86* (Year)

7-AGE

86 yrs. mos. ds. or min.?

If LESS than
1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework.

9-BIRTHPLACE
(State or country)

West River Md.

10-NAME OF FATHER

Unknown.

11-BIRTHPLACE OF FATHER
(State or country)

Unknown.

12-MAIDEN NAME OF MOTHER

Betty Colchan

13-BIRTHPLACE OF MOTHER
(State or country)

Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rachel Taylor.

(Address)

1904 Duvid Hill Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 19, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *May 24, 1915* to *July 18, 1915*, that I saw her alive on *July 7, 1915*, and that death occurred, on the date stated above, at *8 a. m.*
The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Contributory
(SECONDARY)

Old Age
(Duration) yrs. mos. ds.

(Signed)

Edward J. Wheatley, M. D.

July 1915 [Address] *1230 Duvid Hill Ave.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

My Auburn

DATE OF BURIAL

July 21, 1915

20-UNDERTAKER

Samuel T. Henry

ADDRESS

578 N Duvid St.

15-
JUL 21 1915
Filed

DEERT . KRAUTER,
Capital Permit Clerk
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *11*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Marlboro Co. Md.*)St.; yrs. *5* mos. *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH.

Unknown

(Month)

(Day)

(Year)

7-AGE,

63

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), *Maryland*

10-NAME OF FATHER

unknown

11-BIRTHPLACE OF FATHER

(State or Country), *unknown*

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thomas Sellman*(Address) *Marlboro A.A. Co. Md.*

15-

JUL 21 1915

Filed..... 191

ROBERT KRAUTER

BURIAL PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 20

(Month)

(Day)

1915

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

Jan 23 1915, to *July 20 1915*,that I saw him alive on *July 20 1915*,and that death occurred, on the date stated above, at *3:45 P.M.*The CAUSE OF DEATH* was as follows: *operation**Sarcoma of the thigh (left)*
with degeneration(Duration) *2* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

Acute Cardiac Dilatation(Duration) *1* yrs. *1* mos. *1* ds.(Signed) *Herbert C. Blake* M. D.*July 20*, 1915. (Address) *1014 Lafayette Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *5* yrs. *27* mos. *27* ds. In the *63* State *MD*Where was disease contracted, if not at place of death? *Marlboro A.A. Co. Md.*Former or usual residence *Marlboro A.A. Co. Md.*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Campville A.A. Co. Md. *July 21, 1915*

UNDERTAKER

ADDRESS

*J. L. Brown & Sons 108 N. W. 11th St.**Truett A. Smith S.S.-1*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1615 N Chapel* ST.; *8* WARD)

REGISTERED NO. C

2-FULL NAME

Addie Louise Bauman (Bauman)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1615 N Chapel St.* St.; yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, *married*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Aug 22, 1880
(Month) (Day) (Year)

7-AGE,

34 yrs. *10* mos. *28* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Norfolk Virg.

10-NAME OF FATHER,

John L. Jegge

11-BIRTHPLACE OF FATHER

(State or Country),

Virg.

12-MAIDEN NAME OF MOTHER

Ella James

13-BIRTHPLACE OF MOTHER

(State or Country),

Virg.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William Bauman

(Address)

1615 N. Chapel St.

15-

JUL 21 1915

ROBERT L. KRAUSE

Baptist Permit Office

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 20, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 15* 191*4*, to *July 20* 191*5*, that I saw him alive on *July 19* 191*5*, and that death occurred, on the date stated above, at *9:50 A.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *1* yrs. *5* mos. *28* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Jacob Fisher* M. D.*July 20, 1915* (Address) *1926 E. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Norfolk Va**July 23, 1915*

20-UNDERTAKER

ADDRESS

*Rolla S. Turner**1842 N. Brady*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *515 N. Bond* ST.; *7* WARD)2-FULL NAME *Catherine Hammann*(Residence in Baltimore: No. *515 N. Bond* St.; *18* yrs., *10* mos., *10* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

Single

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH.

July 9, 1897
(Month) (Day) (Year)

7-AGE,

18 yrs., *10* mos., *10* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Lakeling
Spice Mill

9-BIRTHPLACE.

(State or Country).

Balto. Md.

10-NAME OF FATHER,

Jacob W. Hammann

11-BIRTHPLACE OF FATHER

(State or Country).

Balto. Md.

12-MAIDEN NAME OF MOTHER

Mollie Mary Thomas

13-BIRTHPLACE OF MOTHER

(State or Country).

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jacob W. Hammann

(Address)

515 N. Bond St.

15-

JUL 21 1915

ROBERT

KRAUTER,

Permit Clerk,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 19, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *May 22* 191*5*, to *July 19* 191*5*, that I saw h. or alive on *July 19* 191*5*, and that death occurred, on the date stated above, at *2:55 p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) *20* yrs., *10* mos., *10* ds.

CONTRIBUTORY (Secondary)

Pulmonary Tuberculosis
(Duration) *20* yrs., *10* mos., *10* ds.
(Signed) *Geo. W. Turner* M. D.
7-19, 1915 (Address) *1937 Gough St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *18* yrs., *10* mos., *10* ds. In the State *18* yrs., *10* mos., *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Catharine bent July 22, 1915

20-UNDERTAKER

ADDRESS

Red L. Turner 1842 N. Bond

Circles of death in plain letters, so that it may be properly transcribed. Last statement in occupation is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH Hahnemann General Hospital,
CITY OF BALTIMORE (No. 1122 N. Mount Street, ST. 16 WARD)

REGISTERED No. C

FULL NAME Charles A. Warfield,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. Non-resident, St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married,
(Write the word.)

6-DATE OF BIRTH, October, 21st, 1891.
(Month) (Day) (Year)

7-AGE, 23 yrs., 8 mos., 29 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Helper on
(b) General nature of industry, business, or establishment in which employed (or employer), motor truck,

9-BIRTHPLACE, (State or Country), Maryland,

PARENTS.
10-NAME OF FATHER, James A. Warfield,
11-BIRTHPLACE OF FATHER (State or Country), Maryland,
12-MAIDEN NAME OF MOTHER, Clara M. Esworthy,
13-BIRTHPLACE OF MOTHER (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Esworthy, uncle,

(Address) Lisbon, Howard County, Md.

15- JUL 21 1915 JOHN A. ESWORTHY REGISTRAR.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of skull caused by being thrown, accidentally, from a motor truck against a steam shovel.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Signed) J. Frederick Kumpke D. (Coroner.)
July 21, 1915 (Address) 3310 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 15 minutes In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Lisbon, Howard Co.

19-PLACE OF BURIAL OR REMOVAL, Lisbon, Howard Co., Md. DATE OF BURIAL, July 21 1915

UNDERTAKER Geo A Gerbey ADDRESS Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Egerton Home Maryland*
CITY OF BALTIMORE (No. *1* ST. *1* WARD) REGISTERED No. C
2-FULL NAME *Charles Frazier* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *Egerton Home* St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *W* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
6-DATE OF BIRTH, *unknown*, 1867 (Month) (Day) (Year)
7-AGE, *48* If LESS than 1 day, (hrs. or min.?)
8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Labourer* (b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), *Va*
10-NAME OF FATHER, *Julius Frazier*
11-BIRTHPLACE OF FATHER, (State or Country), *Va*
12-MAIDEN NAME OF MOTHER, *Martha Paine*
13-BIRTHPLACE OF MOTHER, (State or Country), *Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Fatt*
(Address) *Egerton Home*

15- JUL 21 1915
Filed..... 101.....
REGISTRAR.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 21*, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Artery Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Arterio Sclerosis*

(Duration) yrs. mos. ds.

(Signed) *Samuel C. Frazier* (Coroner)

July 21, 1915 (Address) *3640 Rockland Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, *Flower St. Road* DATE OF BURIAL, *July 21*, 1915

20-UNDERTAKER *A. S. Marshall* ADDRESS *3539 Fall Rd*

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, 8-hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

FOR ANATOMICAL PURPOSES.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C86876

CERTIFICATE OF DEATH

151

C86876

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

1905 Asquith

ST.

9

WARD)

2-FULL NAME

Thos Morgan Jr

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1905 Asquith

St. X yrs. 3 mos. X ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Colored 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH APR 19, 1915 (Month) (Day) (Year)

7-AGE X yrs. 3 mos. X ds. or less than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto Md

10-NAME OF FATHER Thos Morgan

11-BIRTHPLACE OF FATHER (State or country) St Mary's Co Md

12-MAIDEN NAME OF MOTHER Florence Calvery

13-BIRTHPLACE OF MOTHER (State or country) St Mary's Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. JUL 21 1915

ROBERT A. KRATZER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH JULY 19, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from JULY 2, 1915, to JULY 9, 1915, that I saw him alive on JULY 9, 1915, and that death occurred, on the date stated above, at 2 P. m. The CAUSE OF DEATH* was as follows:

Marasmus artificially fed. about 2 weeks (Duration) 1 yrs. 2 mos. X ds

Contributory Marasmus (SECONDARY) (Duration) 1 yrs. 2 mos. X ds

(Signed) O. J. Dyer M. D. JULY 20, 1915 (Address) 928 E. North Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL COLLEGE OF P. & S.

DATE OF BURIAL 1915

20-UNDERTAKER

ADDRESS

Commissioner Health.

FOR ANATOMICAL PURPOSES

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1700 Marshall ST.; 23 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. E. Cro(Residence in Baltimore: No. 1700 Marshall St St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH,

Apr 17, 1915
(Month) (Day) (Year)

7-AGE,

3 yrs., 3 mos., 3 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Child

9-BIRTHPLACE, (State or Country).

Md

10-NAME OF FATHER,

Geo. H. Cro

11-BIRTHPLACE OF FATHER (State or Country).

Md

12-MAIDEN NAME OF MOTHER

Anna E. Pichl

13-BIRTHPLACE OF MOTHER (State or Country).

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. Cro(Address) 1700 Marshall St

15-

JUL 21 1915

Filed

ROBERT E. KRAUTER,

Bureau Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 20, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 17, 1915, to July 20, 1915, that I saw him alive on July 20, 1915, and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Malnutrition

CONTRIBUTORY (Secondary)

Starvation
(Signed) R. H. Campbell M. D.
July 20, 1915 (Address) 1644 B. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill

DATE OF BURIAL,

July 21, 1915

20-UNDERTAKER

Wm. Cook

ADDRESS

502 E. Holl

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 C86878

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

1434 Boyle St.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Jacob Leybold

(Residence in Baltimore: No.

1434 Boyle St.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

Nov. 19, 1865
(Month) (Day) (Year)

7-AGE

49 yrs. 8 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Machinist
R. P.

9-BIRTHPLACE
(State or country)

Cal County, Md.

10-NAME OF FATHER

Geo. Leybold

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Rebecca Jackson

13-BIRTHPLACE OF MOTHER
(State or country)

Cal County, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mary Leybold

(Address)

1434 Boyle St.

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

July 21, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 13, 1915, to July 20, 1915.

that I saw him alive on July 20, 1915.

and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Pulmonalis

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Wm. T. Seabury M. D.

July 21, 1915. (Address) 621 E. Gay Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Georgetown, Md.

7/23, 1915

20-UNDERTAKER

ADDRESS

J. H. M. Bully

39 E. Fort Ave.

JUL 21 1915

ROBERT A. KRAUTER,

City Health Officer

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Brooks(Residence in Baltimore: No. 247 Arlington Ave St.: 6 yrs., 6 mos., 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Black5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Single

6-DATE OF BIRTH.

December 29, 1914
(Month) (Day) (Year)

7-AGE,

6 yrs., 2 mos., 2 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),md

10-NAME OF FATHER,

Thomas Brooks

11-BIRTHPLACE OF FATHER

(State or Country),

Calvert Co. md.

12-MAIDEN NAME OF MOTHER

Florence Brooks

13-BIRTHPLACE OF MOTHER

(State or Country),

Prince Geo. Co. md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Smith(Address) Johns Hopkins Hosp.

JUL 21 1915

Filed July 21, 1915

HARRY O. ANDREWS,

Marial-Permit-Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 20, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 20 1915, to July 20 1915,that I saw him alive on July 20 1915,and that death occurred, on the date stated above, at 4:55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Sublethal Indigestion(Duration) 1 yrs., 1 mos., 1 ds.CONTRIBUTORY
(Secondary)(Duration) 1 yrs., 1 mos., 1 ds.(Signed) G. A. Baller M. D.July 20, 1915 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs., 1 mos., 1 ds. In the State 1 yrs., 1 mos., 1 ds.Where was disease contracted, if not at place of death? ✓Former or usual residence 247 Arlington Ave

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Anthony July 21, 1915

20-UNDERTAKER

ADDRESS

Charmington St. 1364

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Elizabeth Home* ST. *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Elizabeth Home, St. Paul* St.; *9* yrs., *2* mos., *22* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUL 21 1915.

RECORDED

191

HARRY O. ANDREWS,
Marial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

July 10 1915, to July 21 1915,

that I saw him alive on July 21 1915,

and that death occurred, on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Tubercularis
about 6 yrs. 6 mos. 22 ds.CONTRIBUTORY
(Secondary)

(Duration) 6 yrs. 6 mos. 22 ds.

(Signed) Edward J. Smith M. D.

July 21, 1915 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 21 yrs. 6 mos. 22 ds. In the State of Md.

Where was disease contracted, if not at place of death? St. Elizabeth Home

Former or usual residence St. Elizabeth Home

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cem.

July 21 1915

20-UNDERTAKER

ADDRESS

George W. Holland

377 Robert St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 Homewood ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Henrietta B. Jackson(Residence in Baltimore: No. 1917 Homewood Ave St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow6. DATE OF BIRTH, Unknown, 1

(Month)

(Day)

(Year)

7. AGE, 77 yrs., — mos., — ds.If LESS than 1 day, — hrs. or — min.?

8. OCCUPATION:

(a) Trade, profession, or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) None9. BIRTHPLACE, (State or Country), Ind

PARENTS.

10. NAME OF FATHER, Unknown11. BIRTHPLACE OF FATHER (State or Country), Unknown12. MAIDEN NAME OF MOTHER, Unknown13. BIRTHPLACE OF MOTHER (State or Country), Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Woodrow(Address) 1917 Homewood Ave

15.

FILE

JUL 21 1915

HARRY O. ANDREWS,

Marial. Permit. Officer.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH, July 19, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from June 30, 1914 to July 14, 1915, that I saw her live on July 17, 1915, and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) 2 yrs., — mos., — ds.CONTRIBUTORY (Secondary) Exhaustion(Duration) 7 yrs., — mos., — ds.(Signed) P. E. Kelly M. D.July 20, 1915 (Address) for E. Kelly

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence —19. PLACE OF BURIAL OR REMOVAL, Louder ParkDATE OF BURIAL, July 21, 191520. UNDERTAKER, W. J. Jackson & SonADDRESS, 1000 N. Park

C86882

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86882

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: 25 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Unknown, 1

(Month)

(Day)

(Year)

7-AGE,

45 yrs. mos. da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Sailor.

(b) General nature of industry, business, or establishment in which employed (or employer).

Merchant Vessel.

9-BIRTHPLACE, (State or Country),

Va.

PARENTS.

10-NAME OF FATHER,

John Waters

11-BIRTHPLACE OF FATHER (State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Waters

(Address) 814 N. Sardona

JUL 21 1915.

HARRY O. ANDREWS,

Filed..... 1915..

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 20, 1915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 18, 1915, to July 20, 1915,

that I saw him alive on July 19, 1915,

and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute indigestion

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) J. H. Thompson M. D.

July 21, 1915 (Address) 1019 N. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. St. Albans Cemetery

DATE OF BURIAL,

July 22, 1915.

20-UNDERTAKER

Charles B. Jones

ADDRESS

1112 N. Sardona

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 E Farmmount St. 16 WARD)

FULL NAME

Margaretta Trenholm

(Residence in Baltimore: No. 2001 E Farmmount ave St. 16 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Widowed,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

February —, 1872
(Month) (Day) (Year)

7-AGE,

43 yrs. 5 mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

House Super.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

Nicholas Gallen

11-BIRTHPLACE OF FATHER
(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Anna M. Ginzelmans

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Uttermaster

(Address) 2001 E Farmmount

15-JUL 21 1915

HARRY O. ANDREWS,

Filed..... 191.. Social Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb — 1915, to July 19 — 1915,

that I saw her alive on July 18 1915,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. 12 mos. ds.

(Signed) J. M. D.

July 19, 1915. (Address) 128 S. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

July 22 1915

20-UNDERTAKER

Winifred Dippel 378 N. Bond

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St., Life yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April

17

1915

(Month)

(Day)

(Year)

7-AGE,

3 yrs. 4 mos. 4 da.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Harry Miller

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Bertha Miller

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harry Miller

(Address)

1335 N. Bond St.

JUL 21 1915

HARRY O. ANDREWS,

Filed

191

Bariat Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

21

1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 17 1915, to July 21 1915,

that I saw her alive on July 20 1915,

and that death occurred, on the date stated above, at 1:15 a.m.

The CAUSE OF DEATH* was as follows:

Cholera infantum
Septic Disease
(Duration) yrs. mos. 5 da.

CONTRIBUTORY

(Secondary)

Heart Disturbance

(Duration) yrs. mos. 5 da.

(Signed) J. W. Kennedy, M. D.

July 21, 1915 (Address) 708 E. Union St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery

July 22 1915

20-UNDERTAKER

ADDRESS

Henry Lutz

1007 N. Bond

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86885

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C86885

1-PLACE OF DEATH

104
REGISTERED No. C

CITY OF BALTIMORE (No. 1007 E Fork Ave ST. 24 WARD)

2-FULL NAME Mildred Antoinette Allen

(If death occurred in a hospital or institution, give its NAME instead of street and number and full out No. 11.)

(Residence in Baltimore: No. 1007 E Fork Ave St.; yrs. 8 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6-DATE OF BIRTH October 25, 1914
(Month) (Day) (Year)

7-AGE 8 yrs. 25 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore

10-NAME OF FATHER Edward Allen

11-BIRTHPLACE OF FATHER (State or country) Baltimore

12-MAIDEN NAME OF MOTHER Mary C. Schaff

13-BIRTHPLACE OF MOTHER (State or country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Allen

(Address) 1007 E Fork Ave

15. JUL 21 1915 HARRY O. ANDERSON, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 20, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17, 1915 to July 20, 1915

that I saw her alive on July 20, 1915

and that death occurred, on the date stated above, at 11: A m.

The CAUSE OF DEATH* was as follows:

Ileo colitis

(Duration) yrs. mos. 7 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Sidney H. Street M. D.
July 20, 1915 (Address) 1431 E Fork Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. M. Louden Park Cem. July 22, 1915

20-UNDERTAKER

ADDRESS

D. & M. Flynn 1422 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1609 Corrington* ST.: *24* WARD)2-FULL NAME *Bertha Fleischer*(Residence in Baltimore: No. *1609 Corrington* St. *41* yrs., — mon. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(If write the word.)

Married

6-DATE OF BIRTH,

Dec. 16, 1849
(Month) (Day) (Year)

7-AGE,

65 yrs. *7* mos. *3* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment, in which

employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Germany*10-NAME OF
FATHER,*John Feldman*11-BIRTHPLACE
OF FATHER

(State or Country),

*Germany*12-MAIDEN NAME
OF MOTHER*Unknown*13-BIRTHPLACE
OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elias H. Fleischer*(Address) *1609 Corrington St.*

15-

JUL 21 1915

HARRY O. ANDERSON,

F.M.A. 191. Serial Permit 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 19, 1915*that I saw him alive on *July 19, 1915*and that death occurred, on the date stated above, at *5:00* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis(Duration) *1* yrs. — mos. — ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. — mos. — ds.(Signed) *Arthur H. Hanks* M. D.*July 20, 1915* (Address) *1278 Adams*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Cem. July 22, 1915

20-UNDERTAKER

ADDRESS *1039**E. Schloman & Son*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1104 E Monument* ST.; *10* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No.

*Mary E Monaghan**1104 E Monument*St.; *42* yrs., *8* mos., *23* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

*October**28th**1872*

(Month)

(Day)

(Year)

7-AGE,

42 yrs., *8* mos., *23* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laundress
*at home*9-BIRTHPLACE,
(State or Country),*Baltimore Md*

PARENTS.

10-NAME OF FATHER,

*William Monaghan*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore Md*

12-MAIDEN NAME OF MOTHER

*Catherine V Liffley*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Catherine V Monaghan

(Address)

1104 E Monument St

15-

*JUL 21 1915**HARRY O. ANDERSON*

Filed.....

1915

Permit 0107

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 21

(Month)

(Day)

1915

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

Nov 1 1915, to *July 21* 1915,that I saw her alive on *July 20* 1915,and that death occurred, on the date stated above, at *645a* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) *1* yrs., *8* mos., *23* ds.

CONTRIBUTOR (Secondary)

Metastatic carcinoma(Duration) *8* yrs., *8* mos., *23* ds.(Signed) *J. E. Rumbach* M. D.*7-21-15*, 1915. (Address) *1207 E. Monument St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cemetery

DATE OF BURIAL,

July 21st, 1915

20-UNDERTAKER,

George Schilling & Sons

ADDRESS

1126 E Monument St

important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *1513 Union Ave* ST. *13* WARD)

2-FULL NAME *Harry E. Henderson*

(Residence in Baltimore: No. *1513 Union Ave* St. *13* yrs. *7* mos. *7* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 10)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Single*
6-DATE OF BIRTH *June 14 1915*
(Month) (Day) (Year)
7-AGE *1* yrs. *7* mos. *7* ds. or min.?
8-OCCUPATION *Chief*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *1513 Union Ave*

10-NAME OF FATHER *Harry E. Henderson*
11-BIRTHPLACE OF FATHER (State or country) *Balto. Md*
12-MAIDEN NAME OF MOTHER *Elizabeth Pore*
13-BIRTHPLACE OF MOTHER (State or country) *Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Harry E. Henderson*
(Address) *1513 Union Ave*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 21 1915*
(Month) (Day) (Year)

17-HEREBY CERTIFY, That I attended deceased from *July 18 1915* to *July 21 1915*, that I saw him alive on *July 20 1915*, and that death occurred, on the date stated above, at *1513 Union Ave*.

The CAUSE OF DEATH* was as follows:

Exhaustion
Contributor (SECONDARY) *Loose person*
(Duration) *2* yrs. *4* mos. *4* ds.
(Signed) *Wm. M. D.*
7/21 1915 (Address) *2705 Jones Rd*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death *1* yrs. *7* mos. *7* ds. In the State *1* yrs. *7* mos. *7* ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Woodlawn* DATE OF BURIAL *July 22 1915*
20-UNDERTAKER *Chenoweth & Son* ADDRESS *Chestnut*

JUL 21 1915
Filed *191*

HARRY O. ANDREWS,
Serial Permit Clerk,
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1506 Millman* ST.; *7* WARD)

2-FULL NAME

William Ettinger(Residence in Baltimore; No. *1506 Millman*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *—* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE

White

5-SEXUAL

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

*Oct**13**1851*

(Month)

(Day)

(Year)

7-AGE.

63 *9* *5*

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Driver
*Truck*9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

Caroline Ettinger
*1506 Millman St.**Germany*
Germany
Germany

Filed....., 191.....

JUL 21 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*July**20**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 12 1915, to *July* *1915*,that I saw him alive on *July 18 1915*,and that death occurred, on the date stated above, at *6 P* m.

The CAUSE OF DEATH* was as follows:

Tubercular Pyaemia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....*Post-mortem tubercular*
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....*John S. Furr*.....M. D.*7/21/15*, 191..... (Address) *1223 W. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

Baltimore *July 21 1915*

20-UNDERTAKER

ADDRESS

John S. Furr *1223 W. Caroline St.*

Clarence Winder
HEALTH DEPARTMENT—CITY OF BALTIMORE

104
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *10* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *707 Sterling St.* St.; *1* yrs., *1* mos., *1* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

June 29, 1914
(Month) (Day) (Year)

7-AGE,

1 yrs., *1* mos., *1* da.If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

md, (city)

PARENTS.

10-NAME OF FATHER,

Taylor Winder

11-BIRTHPLACE OF FATHER (State or Country),

md.

12-MAIDEN NAME OF MOTHER

Helen Rust.

13-BIRTHPLACE OF MOTHER (State or Country),

md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Phelps*(Address) *Johns Hopkins Hosp.*

15 JUL 22 1915.

ROBERT E. KAUTER,

Filed..... 191. *Regist. Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 13* 191 *5* to *July 21* 191 *5*, that I saw him alive on *July 21* 191 *5*, and that death occurred, on the date stated above, at *10* *10* m.

The CAUSE OF DEATH* was as follows:

Gonitis
Cystitis(Duration)..... yrs..... mos. *8* da.

CONTRIBUTORY (Secondary)

None

(Duration)..... yrs..... mos..... da.

(Signed) *G. A. Batters**July 21* 191... (Address) *Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos. *6* da. In the State..... yrs..... mos..... da.

Where was disease contracted, if not at place of death?

Former or usual residence *707 Sterling St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Long Green Md July 22, 1915.

20-UNDERTAKER

ADDRESS

A. B. Cross 1405 McElderry St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

JUL 22 1915

ROBERT K. KRAUTER

BALTIMORE PERMIT OFFICE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 3, 1915, to July 21, 1915,

that I saw him alive on July 21, 1915,

and that death occurred, on the date stated above, at 2:22 p.m.

The CAUSE OF DEATH* was as follows:

Septicemia
(Duration) 2 yrs. 10 mos. 18 ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. 10 mos. 18 ds.

(Signed) Edward Smith M. D.

July 21, 1915. (Address) 2200 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 18 yrs. 10 mos. 18 ds. In the State 18 yrs. 10 mos. 18 ds.

Where was disease contracted, if not at place of death? East River

Former or usual residence Norway

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Swartz Cemetery July 24, 1915

20-UNDERTAKER

ADDRESS

Robert J. Turner 1442 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

(86892)

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *10*)

FULL NAME

(Residence in Baltimore: No. *10*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SHX.

4-COLOR OR RACE.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word)

6-DATE OF BIRTH

7-AGE,

If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....

9-BIRTHPLACE,

(State or Country).

10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country).12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

JUL 22 1915

Filed.....

191

ROBERT KRAUTER,

Baptist Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

.....191....., to.....191.....

that I saw h..... alive on.....191.....

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the.....yrs.....mos.....ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. Water foot of Hanover St ST. 24 WARD 164)

FULL NAME Carl Theodore Freitag

(Residence in Baltimore: No. 214 E Cross St)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

SP 6 yrs., 6 mos., 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)

6-DATE OF BIRTH, Jan 18, 1889.
(Month) (Day) (Year)

7-AGE, 26 yrs., 6 mos., 1 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Pharmacist
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Md

10-NAME OF FATHER, Henry Freitag

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Josephine Denhard

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. Homer Freitag

(Address) 212 E. Cross St.

15-JUL 22 1915
Filed 191

DEPT. KRAUTER,
Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19, 1915.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.)

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
Fell from his own boat

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Edmund (Coroner) M. D.

July 21, 1915 (Address) 517 S. cott St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, CEDAR HILL

20-UNDERTAKER ARMSTRONG-DENNY CO.

DATE OF BURIAL, JUL 22 1915

ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86891
CERTIFICATE OF DEATH.104
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.; *8* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Baby Smith.(Residence in Baltimore: No. *1604 N. Dallas*St.; yrs. mos. *20* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Blk.*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH.

*June**29*, *1915*

(Month)

(Day)

(Year)

7-AGE.

20 ds.

10 LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country).*Ind.*

10-NAME OF FATHER,

Tom Jenkins

11-BIRTHPLACE OF FATHER

(State or Country).

Va.

12-MAIDEN NAME OF MOTHER

Heutie Smith

13-BIRTHPLACE OF MOTHER

(State or Country).

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

*JUL 22 1915**ROBERT**Barial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*July**19**1915*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 29, 1915*, to *July 19, 1915*, that I saw her alive on *July 18, 1915*, and that death occurred, on the date stated above, at *3:40 A.M.*

The CAUSE OF DEATH* was as follows:

Gastro-enteritis(Duration) yrs. mos. *10* ds.CONTRIBUTORY
(Secondary)*Prematurity*
9 mos child

(Duration) yrs. mos. ds.

(Signed)

Ed. J. H. H.
July 19, 1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *20* ds. In the State yrs. mos. *20* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

1604 N. Dallas St.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

HOPKINS HOSPITAL *JUL 22 1915*

20-UNDERTAKER

ADDRESS

Commissioner Health.

FOR ANATOMICAL PURPOSES

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *2448 Etting St*) ST.: *12* WARD) REGISTERED No. C
2-FULL NAME *James Baytop*
(Residence in Baltimore: No. *2448 Etting St* St.: *7* yrs., *10* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Caucasian* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH, *June 10, 1915* (Month) (Day) (Year)
7-AGE, *7* yrs., *10* mos., *10* ds. If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Infant*
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), *Balt Md*
10-NAME OF FATHER, *Andre Baytop*
11-BIRTHPLACE OF FATHER (State or Country), *Va*
12-MAIDEN NAME OF MOTHER *Mary Baytop*
13-BIRTHPLACE OF MOTHER (State or Country), *Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Andre Baytop*
(Address) *2448 Etting St*

15- JUL 22 1915
Filed 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 20, 1915* (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Enterocolitis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Harry C. Rogers, M.D.*
(Address) *3640 Rockledge*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mount Auburn* DATE OF BURIAL, *July 22, 1915*
20-UNDERTAKER, *John H. Owen* ADDRESS *1222 ...*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 743 W. Lombard ST.; 14 WARD)
2-FULL NAME Thomas F. Farnan
(Residence in Baltimore: No. 743 W. Lombard St.; 69 yrs., 4 mos. 5 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married
6-DATE OF BIRTH, March 15, 1846
(Month) (Day) (Year)
7-AGE, 69 yrs., 4 mos., 5 ds.
8-OCUPATION:
(a) Trade, profession, or particular kind of work, Retired Officer
(b) General nature of industry, business, or establishment in which employed (or employer), Police Department
9-BIRTHPLACE, (State or Country), Maryland

PARENTS.
10-NAME OF FATHER, Michael Farnan
11-BIRTHPLACE OF FATHER (State or Country), Ireland
12-MAIDEN NAME OF MOTHER, Ellen McCabe
13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Frank J. Farnan
(Address), 505 N. Carrollton Ave

15- JUL 22 1915
Filed..... 191.....
ROBERT J. KRAUTH
Serial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July 20, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1915, to July 20 1915, that I saw him alive on July 20 1915, and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Myocardial
Infarction
with
hypertension
(Duration) 2 yrs., 3 mos., 0 ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.
(Signed) G. W. McElroy M. D.
July 20, 1915. (Address) 1415 E. Lombard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Catholic Cem
20-UNDERTAKER
Henry W. Jenkins Sons Co

7-23-1915
ADDRESS Orchard
McCulloch St

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86897

CERTIFICATE OF DEATH.

85
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2733 Harlem Ave. ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Emelie Herald

(Residence in Baltimore: No. 2733 Harlem Ave. St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH

March 2, 1850
(Month) (Day) (Year)

7-AGE

65

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

at Home

9-BIRTHPLACE,

(State or Country)

Herstede-Westphalia-Germany

10-NAME OF FATHER

August Becker

11-BIRTHPLACE OF FATHER

(State or Country)

Westphalia Germany

12-MAIDEN NAME OF MOTHER

Fredericka Westfeldt

13-BIRTHPLACE OF MOTHER

(State or Country)

Westphalia-Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John R. Becker

(Address)

110 Cathedral St.

15-

JUL 22 1915

ROBERT . KRAUTH

Filed

191

Burial Permit Office

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb. 1, 1915, to July 21, 1915

that I saw her alive on July 20, 1915

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Stroke & coronary disease
(arteriosclerosis, thrombosis)

(Duration)....yrs....mos....ds.

CONTRIBUTORY

(Secondary)

(Duration)....yrs....mos....ds.

(Signed).....J. T. Thoma.....M. D.

July 21, 1915 (Address).....1542 Edmond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

New Cathedral

DATE OF BURIAL

July 23, 1915

20-UNDERTAKER

Henry W. Fickens & Sons Co

ADDRESS

Mc Culloch Orchard St.

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Joseph K. Lanocha
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *2108 Aliceanna* ST.: *1*)
2-FULL NAME *Joseph K. Lanocha*
(Residence in Baltimore: No. *2108 Aliceanna*)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, *Single* WIDOWER, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, *April 27, 1915*
(Month) (Day) (Year)
7-AGE, *2 yrs., 2 mos., 25 ds.* If LESS than 1 day,hrs. or....min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER, *Ignatius Lanocha*
11-BIRTHPLACE OF FATHER (State or Country), *Austria*
12-MAIDEN NAME OF MOTHER *Leokadia Barecki*
13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Leokadia Lanocha*
(Address) *2108 Aliceanna St*

15- *JUL 22 1915* *ROBERT KRAUTER*
Filed..... 191..... *Permit Clerk*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 22, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-

inquiry find that said deceased came to *his* death
(topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *D. W. Jones* M. D.
(Coroner.)

July 22, 1915 (Address) *3716 O'Donnell St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

July 22, 1915

20-UNDERTAKER

M. F. Sadowski

ADDRESS

405 S. Ann St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.; *4* WARD)

REGISTERED NO. C _____

2-FULL NAME

(Residence in Baltimore: No. *Mercy Hospital* St.; *5* yrs., *Months* mos., *da.*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

July 31, 1915
(Month) (Day) (Year)

7-AGE,

yrs. mos. da.

If LESS than 1 day,

.... hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*9-BIRTHPLACE,
(State or Country),*Balto. Maryland*

10-NAME OF FATHER,

*Charles Oliver*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Estelle Eckles*13-BIRTHPLACE OF MOTHER
(State or Country),*Minnesota*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thomas K. Gahin*(Address) *Mercy Hospital*

15-

JUL 22 1915 *ROBERT K. KRAUTER,*
Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 31, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 21, 1915, to *July 31, 1915*,that I saw him alive on *July 21, 1915*,and that death occurred, on the date stated above, at *3:30* am.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
*Fractured Skull**due to high fever* (Duration) yrs. mos. da.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) *Edward S. Smith, M.D.**July 22, 1915* (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS),

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence *Mercy Hosp.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Catholic Cemetery *July 23, 1915*

20-UNDERTAKER

Henry H. Jenkins & Sons Co *Archdean St.*

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *107 S. Central Ave* St. *3* WARD)

2-FULL NAME

Annie M. Kelly

(Residence in Baltimore: No. *107 S. Central Ave* St. *3* yrs. *10* mos. *10* ds.)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

July 11th, 1915.
(Month) (Day) (Year)

7-AGE,

10 yrs. *10* mos. *10* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

None

9-BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Denis Maratche

11-BIRTHPLACE OF FATHER (State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Emma Cunningham

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Emma Kelly

(Address).....

107 S. Central Ave

15-

Filed

JUL 22 1915

HARRY O. ANDREWS,

Barial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 21, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy of inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, autopsy of inquiry.) and that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastroenteritis
Heart Failure

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....
(Coroner.) *N. W. Jones* M. D.

July 21, 1915 Address *107 S. Central Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place..... In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

COLLEGE OF P. & S.

JUL 22 1915

20-UNDERTAKER

ADDRESS

Commissioner Health.

FOR ANATOMICAL PURPOSES

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1210 Rutaw Place, ST. 8 WARD)

2-FULL NAME William H. Wallis,

(Residence in Baltimore: No. 1803 N. Broadway,

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married,

6-DATE OF BIRTH, April 16th, 1857. (Month) (Day) (Year)

7-AGE, 58 yrs., 3 mos., 5 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Carpenter. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland,

10-NAME OF FATHER, Unknown, 11-BIRTHPLACE OF FATHER (State or Country), Unknown, 12-MAIDEN NAME OF MOTHER, Unknown, 13-BIRTHPLACE OF MOTHER (State or Country), Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Lily D. Wallis, wife, (Address) 1803 N. Broadway,

15- JUL 22 1915 HARRY O. ANDERSON Registrar. Filed....., 191. Marital Permit. Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 21st, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris, (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) J. Frederick Hempel M. D. (Coroner.) July 22, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rock Spring, Maryland, DATE OF BURIAL, July 23, 1915.

20-UNDERTAKER, William Cook, ADDRESS, 502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86902

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86902

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 124 Riverside Ave ST. 24 WARD)

2-FULL NAME Christina Schuler

(If death occurred in a hospital or institution, give its NAME instead of street and number and list out No. 13.)

(Residence in Baltimore: No. 124 Riverside Ave St.: 70 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word)

6-DATE OF BIRTH Dec 3, 1930
(Month) (Day) (Year)

7-AGE 84 yrs. 7 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Germany

10-NAME OF FATHER W. L. Schuler

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Henry Schuler
(Address) 1241 Riverside Ave

15-
JUL 22 1915
Filed

HARRY O. ANDERSON
Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 21, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1915, to July 21, 1915, that I saw him alive on July 21, 1915, and that death occurred, on the date stated above, at 5:45 m. The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 2 mos. ds.

Contributory (SECONDARY)

(Duration) yrs. 2 mos. ds.

(Signed) H. J. Smith M. D.

July 22, 1915 (Address) 525 Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Western Cemetery DATE OF BURIAL July 24, 1915

20-UNDERTAKER

Geo. L. Schmitt & Bro ADDRESS 2101 Fulton Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86903

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
Announced dead Mary Hospital
CITY OF BALTIMORE (No. _____) ST. 5 WARD

2-FULL NAME Harry R. Sauter
(Residence in Baltimore: No. 154 N. Gay St.)

56
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male
4-COLOR OR RACE White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed
6-DATE OF BIRTH December 16, 1858
(Month) (Day) (Year)

7-AGE, 56 yrs. 7 mos. 8 ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Printer -
(b) General nature of industry, business, or establishment in which employed (or employer). Pressman

9-BIRTHPLACE.
(State or Country), Balto. Co. Md.

10-NAME OF FATHER, Charles Sauter
11-BIRTHPLACE OF FATHER (State or Country), Balto. Co. Md.
12-MAIDEN NAME OF MOTHER, Virginia Dudley.
13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Eliza Baker (Sister)
(Address) 1123 N. Caroline St.

15 JUL 22 1915
Filed _____, 191... HARRY O. ANDREWS,
Serial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute cardiac dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism chronic

(Duration) yrs. mos. ds.

(Signed) H. H. Chambers M. D.
(Coroner) July 22, 1915 (Address) 18 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death:.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park
DATE OF BURIAL, 7/23, 1915

20-UNDERTAKER, John B. Spence
ADDRESS, 1325 N. Carolina

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1109 Ensor*)ST.: *10* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *(1 Life) 1109 Ensor St*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

WIDOWED
(Write the word.)

6-DATE OF BIRTH,

*Unknown**1836*
(Month) (Day) (Year)

7-AGE,

79 yrs. 10 mo. 10 da.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE,

(State or Country),

Balt md

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss A. H. Watts*(Address) *1109 Ensor St*

15-

JUL 22 1915

Filed

191

HARRY O. ANDERSON,

Bureau of Health Officer,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July
(Month)*21*
(Day)*1915*
(Year)17- I HEREBY CERTIFY, That I attended deceased from *June 1*, 191*5*, to *July 21*, 191*5*, that I saw h *2* alive on "*"*" 191*5*, and that death occurred, on the date stated above, at *8:30* p. m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration)

2 yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(Duration)

2 yrs.

mos.

ds.

(Signed) *George A. Hartman*

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

July 23, 1915

20-UNDERTAKER

John B. Palmer

ADDRESS

1325 26 Caroline St

Certificate of Death in plain terms, so that it may be properly understood. Enter statement of occupation in very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86905

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUL 22 1915

HARRY O. ANDREWS,

Fil... 191... Marial Permit Oler

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

May 28, 1915, to July 22, 1915, that I saw him alive on July 22, 1915, and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Elastic Force

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY. (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

July 22, 1915. (Address) 3.4.3.5 Chestnut St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Druid Ridge July 22, 1915.

20-UNDERTAKER

ADDRESS

Chenoweth & Chestnut

Ad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital 11* ST.; *11* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Maryland General Hospital* ST.; *11* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

September 28, 1896
(Month) (Day) (Year)

7-AGE.

*18 yrs. 9 mos. 22 ds.*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Mill Hand*

9-BIRTHPLACE.

(State or Country), *Hillsdale, Md.*

PARENTS.

10-NAME OF FATHER.

Chas. Albert Menzies

11-BIRTHPLACE OF FATHER.

(State or Country), *Balto. Co., Md.*

12-MAIDEN NAME OF MOTHER.

Hannah Johnson Ware

13-BIRTHPLACE OF MOTHER.

(State or Country), *Hillsdale, Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles Menzies*(Address) *Hillsdale, Md.*

15-

JUL 22 1915

Filed..... 191...

HARRY O. ANDREWS,

Marial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 20, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 15, 1915*, to *July 20, 1915*, that I saw him alive on *July 20, 1915*, and that death occurred, on the date stated above, at *10:50 m.*

The CAUSE OF DEATH* was as follows:

Inflammatory appendicitis with Peritonitis

(Duration).....

yrs. mos. ds.

CONTRIBUTORY (Secondary)

Heart

(Duration).....

yrs. mos. ds.

(Signed).....

A. E. Smith, M. D.

M. D.

....., 191... (Address) *4509 W. 11th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....

yrs. mos. ds.

In the

State *18* yrs. *9* mos. *22* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Hillsdale, Maryland

19-PLACE OF BURIAL OR REMOVAL.

Roman Catholic

DATE OF BURIAL.

July 23, 1915

20-UNDERTAKER

Joseph Block

ADDRESS

1003 M. B. Ave.

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *Hebrew Hospital*)

ST. *3* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Myer Patz*

(Residence in Baltimore: No. *244 S. Caroline*)

St. *24* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *married* (If write the word)

6-DATE OF BIRTH *not known*, 1851 (Month) (Day) (Year)

7-AGE *64* yrs. *—* mos. *—* ds. or *—* min. ? If LESS than 1 day, *—* hrs.

8-OCCUPATION (a) Trade, profession, or particular kind of work *Unknown* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Russia*

PARENTS 10-NAME OF FATHER *Mayer Patz* 11-BIRTHPLACE OF FATHER (State or country) *Russia* 12-MAIDEN NAME OF MOTHER *Unknown* 13-BIRTHPLACE OF MOTHER (State or country) *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Harry Patz* (Address) *244 S. Caroline St*

15. JUL 22 1915. ROBERT J. BRAUTER, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 22*, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 20*, 1915, to *July 21*, 1915, that I saw him alive on *July 21*, 1915, and that death occurred, on the date stated above, at *2:20 p. m.* The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach with metastases to the liver (Clinical Diagnosis) (Duration) *6* yrs. *—* mos. *—* ds.

Contributory (SECONDARY) (Duration) *—* yrs. *—* mos. *—* ds. (Signed) *M. B. Levine* M. D. (Address) *Hebrew Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death *5* yrs. *5* mos. *—* ds. In the State *25* yrs. *—* mos. *—* ds. Where was disease contracted, *244 S. Caroline St* If not at place of death? Former or usual residence *244 S. Caroline St*

19-PLACE OF BURIAL OR REMOVAL *Hebrew Rose Dale* DATE OF BURIAL *July 23, 1915* ADDRESS *1101 E* 20-UNDERTAKER *S. Lemmon Bro Balto*

Harrison Woods.
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *1210 Edward St.*CITY OF BALTIMORE: (No. _____) ST.; *5* WARD)

REGISTERED NO. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Woods, Harrison*(Residence in Baltimore: No. *(Mrs. Woods, mother) - 1210 Edward* St.; _____ yrs., _____ mos. *21* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

July 1, 1915
(Month) (Day) (Year)

7-AGE,

21 ds.

If LESS than 1 day, _____ hrs. or _____ min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____*None*

9-BIRTHPLACE, (State or Country).

*1210 Edward St., Baltimore*10-NAME OF FATHER, *Harrison Woods*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Watkins ?*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sora Woods*(Address) *1210 Edward St.*15-*JUL 23 1915*

ROBERT KRAUTER, Registrar.

Filed _____, 1915.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 21, 1915, to *July 21, 1915*,that I saw him alive on *July 21, 1915*,and that death occurred, on the date stated above, at *7:30 am*.

The CAUSE OF DEATH* was as follows:

marasmus

CONTRIBUTORY (Secondary)

(Duration) *Three weeks* yrs. mos. ds.(Signed) *Edward A. Park* M. D.*July 22, 1915* (Address) *Edwards High School*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Asbury *July 23, 1915*

20-UNDERTAKER

ADDRESS

Robt A Elliott 506 East St

important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NCI. C

CITY OF BALTIMORE (No. *Biedler Sellman Sanatorium* ST. *132* WARD)

2-FULL NAME *Emma J. Waron (Laron)*

(Residence in Baltimore: No. *Biedler Sellman Sanatorium* St.: yrs. mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word)

6-DATE OF BIRTH *Nov 4*, 1874
(Month) (Day) (Year)

7-AGE *40* yrs. *8* mos. *18* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country) *York Co., Pa.*

10-NAME OF FATHER *Wm. Melhorn*

11-BIRTHPLACE OF FATHER
(State or country) *York Co., Pa.*

12-MAIDEN NAME OF MOTHER *Sarah Fink*

13-BIRTHPLACE OF MOTHER
(State or country) *York Co., Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Alwyn A. Laron*

(Address) *York Pa*

15- *JUL 23 1915* *ROBERT KRAUTER*
Filed, 191 *Murial Permit Clerk*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 22*, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *7/17*, 1915, to *7/22*, 1915, that I saw her alive on *7/22*, 1915, and that death occurred, on the date stated above, at *11 P.* m. The CAUSE OF DEATH* was as follows:

Tubo salpingitis

Contributory (SECONDARY) *Rupture + Peritonitis*
(Duration) yrs. *6* mos. ds.

(Signed) *Geo. W. W. Hoff* M. D.
7/22, 1915 (Address) *2020 N. Charles St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. *5* ds. In the State yrs. mos. *5* ds.

Where was disease contracted? *York, Pa.*

If not at place of death? Former or usual residence *York, Pa.*

19-PLACE OF BURIAL OR REMOVAL *York, Pa.* DATE OF BURIAL *July 23, 1915*

20-UNDERTAKER *Horace Burgeon* ADDRESS *3631 Falls Rd*

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Chas. C. Elger Jr.
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *Foot of Chester*) ST. *2* WARD) REGISTERED No. C *169* C86910
2-FULL NAME *Chas. C. Elger Jr.*
(Residence in Baltimore: No. *1916 Eastern Ave*) St. yrs. *5* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH, *July 20th, 1894*
(Month) (Day) (Year)
7-AGE, *21* yrs. *1* mos. *1* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer). *E. F. Fote Packing Co.*

9-BIRTHPLACE,
(State or Country).

PARENTS.
10-NAME OF FATHER, *Baltimore*
Chas. C. Elger Jr.
11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*
12-MAIDEN NAME OF MOTHER *Barbara Weber*
13-BIRTHPLACE OF MOTHER (State or Country), *Pa*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Barbara Elger*
(Address) *1916 Eastern Ave*

15- JUL 23 1915 ROBERT KRAUTER,
Filed. 101. *Medical Permit Clerk*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 23rd, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to *his* death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *N. H. Jones* M. D.
(Coroner.)

July 23rd, 1915 (Address) *3116 Oakman St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oak Lawn

July 24, 1915

20-UNDERTAKER

ADDRESS

Peter Nicolais

2044 Eastern Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3514 Walbrook Ave ST. 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. 3514 Walbrook Ave St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

Jul, 21, 1915.
(Month) (Day) (Year)

7-AGE.

Infant
yrs. mos. ds.If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).3514 Walbrook Ave
Baltimore Md

10-NAME OF FATHER,

Geo H Klingenstein

11-BIRTHPLACE OF FATHER
(State or Country).

Phila Pa

12-MAIDEN NAME OF MOTHER

Emma Hutter

13-BIRTHPLACE OF MOTHER
(State or Country).

Belle Mead

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. Klingenstein(Address) 3514 Walbrook Ave

15-

JUL 23 1915

ROBERT KRAUTER

Filed

191. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 21, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
that I saw h. alive on June 21, 1915
and that death occurred, on the date stated above, at home m.

The CAUSE OF DEATH* was as follows:

Premature Birth
6 months
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. K. [Signature] M. D.191... (Address) 3514 Walbrook Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

St. Luke's Cemetery20-UNDERTAKER Geo. L. Schwan & Bro

DATE OF BURIAL.

Jul 23 1915

ADDRESS

3514 Walbrook Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1804 Lorman* ST.; *15* WARD)

REGISTERED NO. C

2-FULL NAME

Minnie Harris

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1804 Lorman*St.; *27* yrs., *7* mos. *17* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female Colored

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH,

Dec. 3, 1888
(Month) (Day) (Year)

7-AGE,

27 yrs., *7* mos., *17* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE,

(State or Country),

Md. Balto.

10-NAME OF FATHER,

Edward Snell

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Isabella Johnson

13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Will Cortes

(Address),

1804 Lorman St.

15 JUL 23 1915

ROBERT . KRAUTER,

Filed....., 191

Royal Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 21, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

*June 15, 1915, to July 18, 1915,*that I saw h. w. alive on *July 18, 1915,*and that death occurred, on the day stated above, at *3:05 P.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration).....yrs. *8* mos.....ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs. mos.....ds.

(Signed) *John S. Quinn* M. D.*July 21, 1915.* (Address) *1507 W. Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Mt Auburn**July 23, 1915.*

20-UNDERTAKER

ADDRESS

James H. Dennis 1303 Preston

Specimen of death in plain terms to that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hahnemann General Hospital* ST. *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *1409 Bruce St.* St. *Lifetown* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)

6-DATE OF BIRTH,

*Dec**5**1903*

(Month)

(Day)

(Year)

7-AGE,

11

yrs.

7

mos.

17

ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*School Girl*9-BIRTHPLACE,
(State or Country),*Balto Md*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUL 23 1915

ROBERT J. KRAUTER,

Burial Permit Clerk

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**22*, *1915*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *June 15* 1915, to *July 22* 1915, that I saw h *u* alive on *July 21* 1915, and that death occurred, on the date stated above, at *4 p.* m.

The CAUSE OF DEATH* was as follows:

*Endocarditis*CONTRIBUTORY
(Secondary)

(Duration)

(Signed)

John A. Evans, M. D.
June 22, 1915. (Address) 1015 Leary St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State 11 yrs. 7 mos. 17 ds.

Where was disease contracted, if not at place of death? *1409 Bruce St*Former or usual residence *1409 Bruce St*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Mt Auburn**July 24 1915*

20-UNDERTAKER

ADDRESS

James H. Dennis / 303 Preston

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 5 North ST.; 4 WARD) REGISTERED NO. C. 170
2-FULL NAME George W. Jolly
(Residence in Baltimore: No. 5 North Street St.; abt 30 yrs., 0 mos., 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
(Write the word.)
6-DATE OF BIRTH, unknown, 1864
(Month) (Day) (Year)

7-AGE, 51 yrs., 0 mos., 0 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Janitor
(b) General nature of industry, business, or establishment in which employed (or employer), Office Building

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, George Jolly

11-BIRTHPLACE OF FATHER (State or Country), MD

12-MAIDEN NAME OF MOTHER, Anna

13-BIRTHPLACE OF MOTHER (State or Country), MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), George Jolly

(Address), 5 North Street

15- JUL 23 1915 ROBERT . KRAUTER

Filed, 191 Mortal Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9 June 1915, to 21 July 1915, that I saw him alive on 21 July 1915, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease
and Complications
(Duration) about 2 months

CONTRIBUTORY (Secondary) Uremia

(Duration) about 3 days
(Signed) Wm. H. Jolly, M. D.
721, 1015 (Address) 430 N. Calver St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Hill

DATE OF BURIAL, July 23, 1915

20-UNDERTAKER, Wm. H. Jolly

ADDRESS, 430 N. Calver St.

Correctness of entries in this certificate may be properly claimed. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1436 Division* ST. *14* WARD)

2-FULL NAME

James Jackson

(Residence in Baltimore: No. *1946 Division*

St.; *12* yrs. mos. ds.)

REGISTERED NO. C. *81*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *Caucasian* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married* (Write the word)

6-DATE OF BIRTH *unknown* 1849 (Month) (Day) (Year)

7-AGE *68* yrs. mos. ds. or min. 1 day, hrs. If LESS than 1 day, hrs. min.?

8-OCCUPATION (a) Trade, profession or particular kind of work *Waiter* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *St Mary's Co Md*

10-NAME OF FATHER *unknown*

11-BIRTHPLACE OF FATHER (State or country) *unknown*

12-MAIDEN NAME OF MOTHER *unknown*

13-BIRTHPLACE OF MOTHER (State or country) *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Elizabeth Jackson*

(Address) *1946 Division*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

7 *20*, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June*, 1914 to *July 20*, 1915, that I saw him alive on *July 18*, 1915, and that death occurred, on the date stated above, at *8:20* a.m. The CAUSE OF DEATH* was as follows:

arteriosclerosis

Contributory (SECONDARY)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Level Bur

July 23, 1915

20-UNDERTAKER

ADDRESS

Amel T. Hensley

578 N. Biddle

15- JUL 23 1915 ROBERT . KRAUTER, Marial Permit Clerk REGISTRAR

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

86916

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *424 Furrow*)

ST. *24* WARD)

FULL NAME

Francis Edward Schmidt

(Residence in Baltimore: No. *424 Furrow*)

St. yrs. *2* mos. *20* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

May 1, 1915
(Month) (Day) (Year)

7-AGE

yrs. *2* mos. *20* ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Baltimore Md

10-NAME OF
FATHER

Frank A Schmidt

11 BIRTHPLACE
OF FATHER
(State or country)

Germany

12 MAIDEN NAME
OF MOTHER

Agnes M McGraw

13-BIRTHPLACE
OF MOTHER
(State or country)

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Schmidt

(Address)

2738 Fredk Ave

15-

JUL 23 1915

ROBERT K. KRAUTER,

Filed

191

Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 20, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1, 1915, to *July 20, 1915*.

that I saw him alive on *July 20, 1915*.

and that death occurred, on the date stated above, at *8:45* m.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) yrs. *19* mos. *19* ds

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *Walter A Cot* M. D.

1-22, 1915 (Address) *545 Sullivan Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

July 23, 1915

20-UNDERTAKER

F. B. Hoppert 2738 Fredk Ave

ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH
CITY OF BALTIMORE (No. *2938 McElderry*, ST. *7* WARD)
FULL NAME *Mary A. Vaughan*
(Residence in Baltimore: No. *2938 McElderry* Sr. yrs. *5* mos. *19* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX *Female* COLOR OR RACE *White* SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
DATE OF BIRTH *Feby. 3, 1915*
AGE *5* yrs. *19* mos. *19* ds. If LESS than 1 day, hrs. or min.?
OCCUPATION *None*
BIRTHPLACE *Baltimore Md.*
PARENTS
10-NAME OF FATHER *John H. Vaughan*
11-BIRTHPLACE OF FATHER *Baltimore Md.*
12-MAIDEN NAME OF MOTHER *Anna A. Byrne*
13-BIRTHPLACE OF MOTHER *Penna.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

JUL 23 1915

ROBERT KRAUTER

Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 23 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 23 1915*, to *July 23 1915*, that I saw her alive on *July 23 1915*, and that death occurred, on the date stated above, at *10 P.* m.
The CAUSE OF DEATH* was as follows:

Acute Cerebral Meningitis

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *C. B. Meyer Jr.* M.D.
July 23, 1915 (Address) *401 N. Lakewood*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery

July 24 1915

20-UNDERTAKER

ADDRESS

E. A. Thidfield Jr.

2113 Gunpowder

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86918

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86918

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *Hebrew-Hospital*

ST. *7*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary King*

(Residence in Baltimore: No. *3529 Fairmont av*

St.: yrs. *7* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6-DATE OF BIRTH *Dec. 10, 1914*
(Month) (Day) (Year)

7-AGE *7* yrs. *12* mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION *Nurse*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Penn.*

10-NAME OF FATHER *William B. King*

11-BIRTHPLACE OF FATHER (State or country) *Tenn. Md.*

12-MAIDEN NAME OF MOTHER *Ella M. Landy*

13-BIRTHPLACE OF MOTHER (State or country) *Balto Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ella M. Landy*

(Address) *3529 Fairmont av*

JUL 23 1915

Filed

191

ROBERT

KRAUTER

Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 22, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 21, 1915* to *July 22, 1915*, that I saw her alive on *July 22, 1915*, and that death occurred, on the date stated above, at *10 A* m. The CAUSE OF DEATH* was as follows:

Intestinal Intoxication

(Duration) yrs. mos. *2* ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) *M. B. Levine* M. D. *July 22, 1915* (Address) *Hebrew Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. *2* ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence *3529 Fairmont av.*

19-PLACE OF BURIAL OR REMOVAL

Schwartz's Cem.

DATE OF BURIAL

July 24, 1915

20-UNDERTAKER

Lilly E. Zeile

ADDRESS

4038 Noefest

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.; *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Francis Gray(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs., *2* mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write the word.*) *Single*

6-DATE OF BIRTH,

May 10, 1915
(Month) (Day) (Year)

7-AGE,

2 mos. 10 ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country).

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUL 23 1915
Filed *191* *ROBERT KRAUTER,*
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 20, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1st* 1915, to *July 20* 1915, that I saw him alive on *July 20* 1915, and that death occurred, on the date stated above, at *9.30 p.m.*

The CAUSE OF DEATH* was as follows:

Malnutrition + Mal assimilation(Duration) yrs. *2* mos. *10* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. *2* mos. *10* ds.(Signed) *J. E. Poulson* M. D.*July 21, 1915* (Address) *615 Columbia St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *2* mos. *10* ds. In the State yrs. *2* mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cathedral July 23, 1915

20-UNDERTAKER

ADDRESS

M. F. Hagen & Sons 606 Lafayette

Certificate of Death is a public record, and its use is restricted. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86920

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's chfrt Asy* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Clrene Tarleton*(Residence in Baltimore: No. *St. Vincent's chfrt Asylum* St.: *1* yrs. *1* mos. *da*)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

June 18, 1914
(Month) (Day) (Year)

7-AGE,

1 yrs. *1* mos. *da*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St*

15-

JUL 23 1915

Filed

191

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 18, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 17 1915 to July 18th 1915
that I saw h. *er* alive on *July 17th 1915*and that death occurred, on the date stated above, at *9:00 a.m.*

The CAUSE OF DEATH* was as follows:

Heat exhaustion(Duration) *2* yrs. *2* mos. *da*

CONTRIBUTORY (Secondary)

(Duration) *2* yrs. *2* mos. *da*(Signed) *J. P. Boulton* M. D.*July 17, 1915* (Address) *615 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *da* In the State *1* yrs. *1* mos. *da*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral July 23, 1915

20-UNDERTAKER

ADDRESS

M. Fahy & Sons 606 Lafayette St

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST. *14* WARD)

2-FULL NAME

James Cadden

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; *1* yrs. *4* mos. *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

February 24, 1914
(Month) (Day) (Year)

7-AGE,

1 yrs. *4* mos. *27* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUL 23 1915

ROBERT KRAUTER

Bureau of Health

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 21, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 13th* 1915, to *July 20* 1915, that I saw him alive on *July 20* 1915, and that death occurred, on the date stated above, at *5.30 a.m.* The CAUSE OF DEATH* was as follows:*Gastro-enteritis*(Duration)....yrs....mos....*7* ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) *J. E. Paulton* M. D.*July 21, 1915* (Address) *615 Columbia Ave.*
per John A. Maxwell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *4* mos. *27* ds. In the State *1* yrs. *4* mos. *27* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral July 23, 1915

20-UNDERTAKER

ADDRESS

M. Fahy - 1006 Lafayette

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 Linden Ave. ST.; 14 WARD)2-FULL NAME Albert J. Saciar(Residence in Baltimore: No. 1735 Linden Ave. St.; 45 yrs., 4 mos., 23 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH.

March 29th, 1863.
(Month) (Day) (Year)

7-AGE.

52 yrs., 3 mos., 23 ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Physician

9-BIRTHPLACE, (State or Country).

Pa.

10-NAME OF FATHER,

Chas. S. Saciar

11-BIRTHPLACE OF FATHER (State or Country).

Pa.

12-MAIDEN NAME OF MOTHER

Mary M. Scholl

13-BIRTHPLACE OF MOTHER (State or Country).

Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Muriel N. Saciar(Address) 1735 Linden Ave.

15-

JUL 24 1915HARRY O. ANDREWSSerial Permit No. 112

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 22, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 15, 1915, to July 22, 1915, that I saw him alive on July 22, 1915, and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia(Duration) ... yrs. ... mos. ... ds. 7

CONTRIBUTORY (Secondary)

Acute dilatation heart(Duration) ... yrs. ... mos. ... ds. 4(Signed) J. Frederick Lait M. D.July 23, 1915. (Address) 1040 E. 11th St.
State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the ... State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Armit Ridge

DATE OF BURIAL.

July 24, 1915.

20-UNDERTAKER

E. M. Mitchell & Co.

ADDRESS

1201 W. Fayette

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86923

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86923

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *2329 Mondawmin Ave.* ST. *15* WARD)

2-FULL NAME *Annie E. Ritter,*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *2329 Mondawmin Ave.* St. *46* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

female.

4-COLOR OR RACE

white.

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

widow.

6-DATE OF BIRTH

Don't know, 18*40*
(Month) (Day) (Year)

7-AGE

75 yrs. *Don't know* mos. ds.

If LESS than
1 day.....hrs.
or—min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

retired.
Housewife

9-BIRTHPLACE
(State or country)

Baltimore Md.

10-NAME OF FATHER

John Huggins

11-BIRTHPLACE OF FATHER
(State or country)

md.

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER
(State or country)

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Harrison

(Address)

2329 Mondawmin Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 22, 191*5*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 19, 191*5*, to *July 22*, 191*5*.

that I saw her alive on *July 22*, 191*5*.

and that death occurred, on the date stated above, at *11⁴⁰* p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

Contributory
(SECONDARY)

Indefinite
(Duration) yrs. mos. ds.

(Signed), *Hand L. Macht* M. D.

July 23, 191*5* (Address) *328 Rochester Terrace*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

July 24, 191*5*

20-UNDERTAKER

ADDRESS

John B. Spence

1325 R. Caroline St.

JUL 24 1915.

HARRY O. ANDREWS,

Sanial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

86924
 1-PLACE OF DEATH
 CITY OF BALTIMORE: (No. *Johns Hopkins Hsp. 7* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME *Ebene Johnson*
 (Residence in Baltimore: No. *1522 Ashland Ave* St. *Life* yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *Black* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
 (Write the word.)
 6-DATE OF BIRTH. *June 23, 1896*
 (Month) (Day) (Year)

7-AGE. *19* yrs. *1* mos. ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Housework*
 (b) General nature of industry, business, or establishment in which employed (or employer). *General*

9-BIRTHPLACE, (State or Country), *Md (Baltimore)*

10-NAME OF FATHER, *James Walker*
 11-BIRTHPLACE OF FATHER (State or Country), *Md*
 12-MAIDEN NAME OF MOTHER *Lucy Barnes*
 13-BIRTHPLACE OF MOTHER (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Phelps*
 (Address) *Johns Hopkins Hsp.*

15- *JUL 24 1915* *CASBY O. ANDREWS,*
 Filed *1915* *Permit Clerk*
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 23, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 19, 1915* to *July 23, 1915*, that I saw her alive on *July 23, 1915*, and that death occurred, on the date stated above, at *2:15* m.

The CAUSE OF DEATH* was as follows:

meningitis (Septic)
 (Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary) *Typhoid fever*
 (Duration)yrs.mos.ds.

(Signed) *Stanhope Bayard Jones* M. D.
July 23, 1915 (Address) *Johns Hopkins Hsp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos. *4* ds. In the *19* yrs. *1* mos. ds.

Where was disease contracted, if not at place of death? *✓*

Former or usual residence *1522 Ashland Ave*

19-PLACE OF BURIAL OR REMOVAL, *Walters Mt. Co. Md* DATE OF BURIAL, *July 24, 1915*

20-UNDERTAKER, *Sam'l W. Chase & Son* ADDRESS *1400 Woodrow*

Examine certificate in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86925

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

C86925

PLACE OF DEATH
CITY OF BALTIMORE: (No. 738 W. Lexington ST. 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Anna Margaret Barry
(Residence in Baltimore: No. 738 W. Lexington St.; 6 yrs. 6 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX female 4-COLOR OR RACE white 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
6-DATE OF BIRTH Jan 17, 1915 (Month) (Day) (Year)
7-AGE 6 yrs. 6 mos. 6 ds. or min. If LESS than 1 day, hrs.
8-OCCUPATION (a) Trade, profession or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore Md.

PARENTS
10-NAME OF FATHER Wm H. Barry
11-BIRTHPLACE OF FATHER (State or country) Balto.
12-MAIDEN NAME OF MOTHER Mary Biemiller
13-BIRTHPLACE OF MOTHER (State or country) Phil. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm H. Barry
(Address) 838 W. Lexington

15-

JUL 24 1915

HARRY O. ANDERSON

Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 23, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 20, 1915, to July 23, 1915, that I saw her alive on July 22, 1915, and that death occurred, on the date stated above, at 8:45 a.m. The CAUSE OF DEATH* was as follows:
enterocolitis

(Duration) yrs. 1 mos. 6 ds.
Contributory (SECONDARY) Contribution
(Duration) yrs. 1 mos. 1 ds.
(Signed) H. E. Knapp M. D.
July 23, 1915 (Address) 1062 W. Lombard

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Mary's Cemetery July 25, 1915

20-UNDERTAKER ADDRESS

St. Mary's Cemetery 442 N. Bond

C86926

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 C86926
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3747 Marley St.* WARD *20*)

2-FULL NAME

(Residence in Baltimore: No. *3747 Marley* St.; yrs. mos. ds.)*Catherine McBride*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

5 Weeks

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH,

June 16, 1915
(Month) (Day) (Year)

7-AGE,

5 Weeks
yrs. mos. ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Catherine McBride

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent de Paul Co.*(Address) *827 Law Building*

15- JUL 24 1915

HARRY O. ADAMS

Filed..... 191..... Serial Permit. Oler

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 23, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 18, 1915*, to *July 23, 1915*, that I saw her alive on *July 122, 1915*, and that death occurred, on the date stated above, at *2 A* m.

The CAUSE OF DEATH* was as follows:

Acute Gastric Enteritis
(Duration) yrs. mos. ds. *14*

CONTRIBUTORY (Secondary)

(Signed) *Howard W. Jones* M. D.
July 23, 1915 (Address) *Dwight St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

July 24, 1915

20-UNDERTAKER

J. M. Donahoe

ADDRESS

1124 Mt Royal Ave

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2044 Linden Ave. ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Abraham S. Adler

(Residence in Baltimore: No.

2044 Linden Ave.

St.; unknown yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH,

April 12th. 1831. 1
(Month) (Day) (Year)

7-AGE,

84 yrs. 3 mos. 10 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Retired

(b) General nature of industry, business, or establishment in which employed (or employer).

Merchant (Shoe)

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

Simon Adler

11-BIRTHPLACE OF FATHER

(State or Country), Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Adler.

(Address) 2044 Linden Ave.

15-

JUL 24 1915 HARRY O. ANDREWS
Filed....., 191... Marial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10, 1915, to July 22, 1915, that I saw him alive on July 22, 1915, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial infarction

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jose L. Fisher, M. D.

July 23, 1915 (Address) 1819 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Hebrew Cem. 7/24, 1915

20-UNDERTAKER

ADDRESS

David Sordheim 118 W. Royal Ave.

Important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1206 Mosher ST. 16 WARD)

2-FULL NAME Joseph Kellermeyer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1206 Mosher St. St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

white

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widower

6-DATE OF BIRTH

June
(Month)

19 1895
(Day) (Year)

7-AGE

80

6

9

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

House painting

9-BIRTHPLACE

(State or country)

Germany

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER

(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Kellermeyer

(Address)

1206 W. Mosher St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July
(Month)

22
(Day)

1915
(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1, 1915, to, July 22, 1915,

that I saw him alive on July 21, 1915,
and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

Parelysis

Contributory
(SECONDARY)

3 yrs. 2 mos. 2 ds.
Old stroke Parelysis

(Signed),

Dr. James M. D.
July 22, 1915. [Address] 9234 Connelley

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Peter's Church Road July 24, 1915

20-UNDERTAKER

ADDRESS

Mr. W. A. Son-2503-Edmondson
ave

JUL 24 1915

Filed

191

HARRY O. ANDREWS

Sanial Permit Officer

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 8

WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; — yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH.

Unknown, 1873

(Month)

(Day)

(Year)

7-AGE.

40

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

Factory

9-BIRTHPLACE.

(State or Country).

Virginia

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER

(State or Country).

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James Brown

(Address)

1317 N Chapel St

15-

JUL 24 1915.

HARRY O. ANDERSON,

Filed....., 191... Serial Permit Order

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 21, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 15 1915, July 21 1915,

that I saw him alive on July 21 1915,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration)..... yrs..... mos. 14. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Matty W. White, M. D.

July 23 1915 (Address) 101 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Arling Court

DATE OF BURIAL.

July 24, 1915.

20-UNDERTAKER.

Harry A. Volery

ADDRESS

1725 Orleans St

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1216 Brentwood* *an* *10* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1216 Brentwood* St.; — yrs., — mos., — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

Don't Know, 1

(Month)

(Day)

(Year)

7-AGE,

*about**77* yrs.

mos.

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

House work

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Ireland

10-NAME OF FATHER,

Michel O'Connor

11-BIRTHPLACE OF FATHER,

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER,

Not known

13-BIRTHPLACE OF MOTHER,

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lizzie Collins

(Address)

1216 Brentwood an

15-

*JUL 24 1915**HARRY O. ANDREWS,**Sanial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 22, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 15, 1915, to July 22, 1915,*that I saw her alive on *July 22, 1915,*and that death occurred, on the date stated above, at *4 P. m.*

The CAUSE OF DEATH* was as follows:

arteriosclerosis(Duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) *6* yrs. mos. ds.(Signed) *James M. Beaton* M. D.*July 23, 1915.* (Address) *702 E. Chase St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

July 24, 1915

20-UNDERTAKER

William Cook

ADDRESS

602 E. North Ave

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 C86931
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 E 20th St. ST. 9 WARD)

2-FULL NAME

Larson C. Jumps

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 718 E 20th St.

St.; 51 yrs., mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word.)

Married

6-DATE OF BIRTH,

June 27, 1864
(Month) (Day) (Year)

7-AGE,

51 yrs., mos. 25 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Auditor & Bookkeeper

9-BIRTHPLACE,

(State or Country),

Md. City

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

Dout Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

JUL 24 1915

HARRY O. ANDREWS,

Filed....., 191. Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 22, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16, 1915, to July 22, 1915, that I saw him alive on July 21, 1915, and that death occurred, on the date stated above, at 11:20 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(Duration).....yrs....2 mos....7 ds.

CONTRIBUTORY (Secondary)

Endocarditis
(Duration).....yrs....2 mos....7 ds.
(Signed).....J. T. O'Leary, M. D.
101... (Address) 1603 B. B. B. B.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Clear July 25, 1915.

20-UNDERTAKER

ADDRESS

Wm. Cook 502 E. North

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2404 St Paul* ST.; *12* WARD)2-FULL NAME *Thomas J Hungerford*(Residence in Baltimore: No. *2404 St Paul* St.; — yrs. — mos. *2* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)6-DATE OF BIRTH *Sept 3 1866*

(Month)

(Day)

(Year)

7-AGE *49* yrs. *10* mos. *20* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
*Farmer*9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Wm H Hungerford*11-BIRTHPLACE OF FATHER, (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Mary J. Tucker*13-BIRTHPLACE OF MOTHER, (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thomas J Hungerford*(Address) *Care Permit Md*

JUL 24 1915.

HARRY O. ANDREWS,

Filed....., 191. Serial. Permit. Clark
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 23rd 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 22 1915*, to *July 23 1915*, that I saw him alive on *July 23rd 1915*, and that death occurred, on the date stated above, at *2:30* m.
The CAUSE OF DEATH* was as follows:*Gastro Enteritis*

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY. *Unhealthy*
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....*Geo H Carver*.....M. D.*July 23 1915*. (Address) *218 26th St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Care Permit Md*DATE OF BURIAL, *7/24, 1915*20-UNDERTAKER *Melvin Cook*ADDRESS *502 E North*

Causes of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86933

CERTIFICATE OF DEATH.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2706 O'Donnell ST.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2706 O'Donnell St.; 35 yrs., 5 mos., 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Feb 12, 1861
(Month) (Day) (Year)

7-AGE,

54 yrs., 5 mos., 10 ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

house work

at home

9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

Adam Weissmantel

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Catherine Andrews

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philipp J. Boerning(Address) 2706 O'Donnell St.

15- JUL 24 1915. ROBERT KRAUTER,
Filed..... 1915. Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 22, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 12 1915, to July 22 1915, that I saw her alive on July 22 1915, and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) H. B. D. Thew M. D.July 23 1915 (Address) 2706 O'Donnell St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Cemetery July 24 1915.

20-UNDERTAKER

ADDRESS

H. Sander & Son 1710 E. St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH Saint Peter's Lane, south of
CITY OF BALTIMORE (No. Walbrook Station, N.M.R.W.St. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME James M. Flint,

(Residence in Baltimore: No. Saint Peter's Lane, (no number) St.; yrs., mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE. White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH. June 30th, 1915. (Month) (Day) (Year)

7-AGE. 0 yrs. 0 mos. 23 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), Baltimore, Md.

PARENTS. 10-NAME OF FATHER. Joseph G. Flint, 11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md. 12-MAIDEN NAME OF MOTHER. Mary B. Jacobs, 13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Mary B. Flint, mother, (Address) Saint Peter's Lane.

15- JUL 24 1915 ROBERT KRAUTH, Burial Permit Clerk, Filled, 191. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 23, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital asthma- caused by prematurity- 7 months Utero- gestation, (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) M. D. (Coroner.) July 23, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, New Calhoun Cem. July 23, 1915

20-UNDERTAKER, ADDRESS, Josiah Syfer 1600 N. North ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1513 Byrd* ST. *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Lawrence J. Durm*(Residence in Baltimore: No. *1513 Byrd* St.; *48* yrs., *4* mos. *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, *Married*, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *Feb 28, 1867*

(Month)

(Day)

(Year)

7-AGE, *48* yrs., *4* mos., *24* ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Clerk.*(b) General nature of industry, business, or establishment in which employed (or employer). *Gen office work*9-BIRTHPLACE, (State or Country), *Balto City*10-NAME OF FATHER, *Jacob Durm*11-BIRTHPLACE OF FATHER (State or Country), *Penn*12-MAIDEN NAME OF MOTHER, *Catherine Bopp*13-BIRTHPLACE OF MOTHER (State or Country), *Balto, Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Lawrence Durm*(Address) *1513 Byrd St*

15-

Filed

JUL 24 1915

ROBERT KRAUTER,

Baltimore Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *7 22, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *7.8* 1915, to *7.22* 1915,that I saw him alive on *7.22* 1915,and that death occurred, on the date stated above, at *11:45* a.m.

The CAUSE OF DEATH* was as follows:

*Cancer of Stomach (Esophagus)**from History* (Duration) yrs. mos. ds.CONTRIBUTORY (Secondary) *Diagnosed at Hopkins*

(Duration) yrs. mos. ds.

(Signed) *L. J. Durmington* M. D.*7.22.1915* (Address) *102 E. Fort a*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Landon Park*DATE OF BURIAL, *July 25, 1915*20-UNDERTAKER *Leo. G. Cook*ADDRESS *1106 Patterson**Ph Ave*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH

502 Wyeth St

CERTIFICATE OF DEATH

CITY OF BALTIMORE: (No. _____)

ST.: 21 WARD)

REGISTERED NO. C _____

2-FULL NAME

August von C. Boecker

(Residence in Baltimore: No. _____)

202 Wyeth St

St.: 50 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

August 10, 1830

(Month)

(Day)

(Year)

7-AGE,

84 yrs., 10 mos., 12 ds.

IF LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Tailor

9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

Henry Boecker

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Justine Thayer

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(Address).....

JUL 24 1915

Filed.....

ROBERT KRAUTER

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 22, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from July 20, 1915, to July 22, 1915, that I saw him alive on July 22, 1915, and that death occurred, on the date stated above, at 5:10 Pm.

The CAUSE OF DEATH* was as follows:

Sensibility
Generalized Arterio
Sclerosis (Duration) 5 yrs., mos., ds.CONTRIBUTORY
(Secondary)

(Signed) M. L. D. July 22, 1915. (Address) 95 Green St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cem.

DATE OF BURIAL,

7-24, 1915

ADDRESS

Orchard McCallum

20-UNDERTAKER

J. M. Jenkins & Son

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 Brookfield Ave ST. 13 WARD)

2-FULL NAME

Antoinette W. Sand (Land)(Residence in Baltimore: No. 2018 Brookfield Ave

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 25 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

WIDOWEDOR DIVORCED

(Write the word.)

Widower

6-DATE OF BIRTH.

April 18th, 1836
(Month) (Day) (Year)

7-AGE.

79 yrs., 3 mos., 5 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none9-BIRTHPLACE,
(State or Country),Va.

10-NAME OF FATHER,

Thos. M. Walker

11-BIRTHPLACE OF FATHER

(State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Johanna S. Smith

13-BIRTHPLACE OF MOTHER

(State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Florence S. Taylor

(Address)

2018 Brookfield Ave

15-

JUL 24 1915ROBERTKRAUTER,191 Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July, 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 23, 1915, to July 23, 1915,that I saw her alive on July 22, 1915,and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY
(Secondary)Senile Myocarditis
(Duration) ... yrs. ... mos. ... ds.

(Signed)

Jos. M. Graybill M. D.
July 24, 1915 (Address) 1800 St. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Amrit Ridge

DATE OF BURIAL.

July 26, 1915

20-UNDERTAKER

E. M. Mitehell & Co. 2018 Fayette

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86933

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 50 Temple St. ST.; 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: 15 yrs., 1 mo., 17 da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

male

4-COLOR OR RACE,

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

single

6-DATE OF BIRTH,

July 6, 1900
(Month) (Day) (Year)

7-AGE,

15 yrs., 1 mo., 17 da.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Trimmer in
Tailor mens
clothing9-BIRTHPLACE,
(State or Country),md.

10-NAME OF FATHER,

Daniel J Smith11-BIRTHPLACE OF FATHER
(State or Country),md.

12-MAIDEN NAME OF MOTHER

Tamerson13-BIRTHPLACE OF MOTHER
(State or Country),md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Smith(Address) 50 Temple St.

15-

JUL 24 1915 ROBERT KRAUTER,
191 121 Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 23, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Feb. 1915, to July 22 1915,
that I saw him alive on July 22 1915,
and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 6 yrs., 1 mo., 15 da.

CONTRIBUTORY

(Secondary)

meningitis (Duration) 4 yrs., 4 mo., 4 da.(Signed) D. A. Nielsen M. D.July 23 1915 (Address) 1420 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 15 yrs., 1 mo., 17 da. In the State 15 yrs., 1 mo., 17 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel

DATE OF BURIAL,

July 24 1915

20-UNDERTAKER

ADDRESS

John W. Henderson 314 Caroline

System of entries in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1113 Biny* ST. *1* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1113 S. Biny St* St. *1* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE

Single
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

July 23, 191*5*
(Month) (Day) (Year)

7-AGE,

..... yrs. mos. ds.

If LESS than 1 day,

2 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*Roman Tatinski*11-BIRTHPLACE OF FATHER
(State or Country),*Russia Poland*

12-MAIDEN NAME OF MOTHER

*Maryana Skrzyn*13-BIRTHPLACE OF MOTHER
(State or Country),*Austria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Roman Tatinski*(Address) *1113 S. Biny St.*

15-

JUL 24 1915**ROBERT KRAUTER**

Filed 191... Burial Permit No.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 23, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 23 191*5*, to *July 23* 191*5*,that I saw him alive on *July 23* 191*5*,and that death occurred, on the date stated above, at *9* p. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
& 4 to 6 month utero gestation
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. H. McAvoy* M. D.*July 24*, 191*5* (Address) *839 S. Edmond St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus Church

DATE OF BURIAL,

July 24, 191*5*

20-UNDERTAKER

Stephen P. Fialkowski 1019 S. ...

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1604 E. Federal St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1604 E. Federal*)St.; yrs. *1* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

*June**16**1857*

(Month) (Day) (Year)

7-AGE,

*58**1**7*

ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, business, or establishment in which

employed (or employer).....

Housekeeper

9-BIRTHPLACE,

(State or Country),

Queen Anne Co Md

PARENTS.

10-NAME OF FATHER,

James Henry Costin

11-BIRTHPLACE OF FATHER

(State or Country), *Va*

12-MAIDEN NAME OF MOTHER

Charlotte Isabelle Wood

13-BIRTHPLACE OF MOTHER

(State or Country), *Caroline Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Nellie Costin*(Address) *1604 E. Federal St.*

15-

JUL 24 1915

ROBERT KRAUTER

Filed..... 191.....

191.....

BURIAL PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 23

(Month)

(Day)

1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from *July 13* 1915, to *July 23* 1915, that I saw her alive on *July 23* 1915, and that death occurred, on the date stated above, at *11 P.* m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation from Valvular Disease of the Heart.(Duration) *7* yrs. *1* mos. *7* ds.

CONTRIBUTORY (Secondary)

Dropsy(Duration) *18* yrs. *18* mos. *18* ds.(Signed) *H. G. Coppard**7/23*, 1915 (Address) *2 St. Patterson Park*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Caroline Co Md

DATE OF BURIAL,

20-UNDERTAKER

Wm. J. Tupper Son

ADDRESS

Room 11 Montz

Specimen of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1134 Jenkins alley* ST. *11* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1134 Jenkins alley* St.; *6* yrs., *6* mos. *6* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male.

4-COLOR OR RACE.

*Cal*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

Sept 10, 1885
(Month) (Day) (Year)

7-AGE.

29 yrs. *10* mos. *14* ds. *14* hrs. or *14* min.?

IF LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Laborer.*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country).

Virginia

10-NAME OF FATHER.

Reston Reed

11-BIRTHPLACE OF FATHER (State or Country).

Virginia

12-MAIDEN NAME OF MOTHER.

Polly Morton

13-BIRTHPLACE OF MOTHER (State or Country).

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Cornelia Howell*(Address) *579 Greenwillow St.*

15-JUL 24 1915

ROBERT . KRAUTER,

Burial Permit Clerk.

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 24, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *June 1st* 1915, to *July 24* 1915, that I saw him alive on *July 23* 1915, and that death occurred, on the date stated above, at *12* m. The CAUSE OF DEATH* was as follows:*Pulmonary Consumption*(Duration)..... yrs. *8* mos. *14* ds.

CONTRIBUTORY (Secondary)

Exhaustion (Duration)..... yrs. *14* mos. *14* ds.(Signed) *Samuel A. Brown* M. D.*July 24, 1915* (Address) *937 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. *6* mos. *6* ds. In the State..... yrs. *6* mos. *6* ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*Samuel Brown**July 24, 1915*

20-UNDERTAKER

ADDRESS

Samuel Brown

Correctness of entries in plain text, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Esther Tominichson
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hop.* ST. *6* WARD)

2-FULL NAME

(Residence in Baltimore: No. *119 N. Spring St.* St.: *4* yrs., *4* mos., *4* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15

JUL 24 1915

ROBERT KRAUTER,

Filed.....*119 N. Spring St.* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 23, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 9 1915, to *July 23* 1915.

that I saw him live on *July 23*, 1915,

and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(Duration).....yrs.....mos.....da.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....da.

(Signed) *Alfred S. Rolleston* M.D.
July 23 1915. (Address) *Johns Hopkins Hop.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence *119 N. Spring St.*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Lebanon Cemetery *July 24* 1915.

20-UNDERTAKER

ADDRESS

S. L. Lumsden *Buon Buono*

Correctness of death in print terms is that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122 86943

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 M^cCallish ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H Hall

(Residence in Baltimore: No. 1722 M^cCallish

St.; 14 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH.

November, 1860
(Month) (Day) (Year)

7-AGE.

50 yrs.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country).

Ind

10-NAME OF FATHER.

Chas Hall

11-BIRTHPLACE OF FATHER

(State or Country).

Ind

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER

(State or Country).

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Samuel Hall

(Address)...

1722 M^cCallish

15-JUL 25 1915 ROBERT KRAUTER, Burial Permit Clerk

Filed..... 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 22, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 6, 1915, to July 22, 1915.

that I saw him alive on July 22, 1915.

and that death occurred, on the date stated above, at 8:15 p.m.

The CAUSE OF DEATH* was as follows:

Dysentery

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *618 N. Chapel*ST.; *7* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *618 N. Chapel*St.; *unknown* yrs., *unknown* mos. *unknown* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*Colored*5-SINGLE, *married*
MARRIED, *married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

unknown, *1858*
(Month) (Day) (Year)

7-AGE,

*57*yrs. *—* mos. *—* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Stevens

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Walter Crosby

(Address),

618 N. Chapel St.

15- JUL 25 1915

ROBERT KRAUTER,

Filed..... 191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

7 — *23*, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 20 - 1915* to *July 23 1915*, that I saw him alive on *July 23 1915*, and that death occurred, on the date stated above, at *11:30 p.m.*
The CAUSE OF DEATH* was as follows:*Pneumonia*
infebrile
(Duration) *2* yrs. *23* ds.

CONTRIBUTORY (Secondary)

(Duration) *2* yrs. *23* ds.(Signed) *Geo. H. Longmire* M. D.*July 24 1915* (Address) *1017 N. Main St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *—* mos. *—* ds. In the State yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Asbury Cem.

DATE OF BURIAL,

July 24, 1915

20-UNDERTAKER

Harry A. Todery

ADDRESS

1725 Orleans St.

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 N Chester ST. 7 WARD)2-FULL NAME Thomas M. Warden(Residence in Baltimore: No. 910 N Chester St.: Life yrs. 0 mos. 0 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOW,

OR DIVORCED.

(Write the word.)

Single

6-DATE OF BIRTH.

Oct 16, 1869
(Month) (Day) (Year)

7-AGE.

45 yrs. 9 mos. 7 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Printer9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER.

David G. Warden11-BIRTHPLACE OF FATHER
(State or Country),Md.

12-MAIDEN NAME OF MOTHER.

May A. Crockett13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

May A. Crockett
(Address) 910 N Chester

15-

JUL 25 1915

ROBERT J. KRAUTER

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 23, 1915, to July 23, 1915,that I saw him alive on July 23, 1915,and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Regurgitationfrom heart (Duration) 0 yrs. 8 mos. 0 ds.CONTRIBUTORY
(Secondary)(Duration) 0 yrs. 8 mos. 0 ds.

(Signed)

W. G. Gushung M. D.
July 23, 1915 (Address) 3100 N. Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 ds. In the 0 yrs. 0 mos. 0 ds. State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Landen Park CemeteryJuly 25, 1915

20-UNDERTAKER

ADDRESS

Albert C. Fuller221 N. Brady

Cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x108

PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hospital* ST. *7* WARD)FULL NAME *Frank Walter*(Residence in Baltimore: No. *John Hopkins Hospital* St. *7* yrs. *10* mos. *10* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, *Married* WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH. *September 29th*, 1854.
(Month) (Day) (Year)

7-AGE. *60* yrs. *10* mos. *25* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Real Estate*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

*Maryland*10-NAME OF FATHER, *Sept. 11. Walter*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Albina Landstreet*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Rosgel*(Address) *John Hopkins Hospital*

15-

JUL 25 1915

ROBERT

KRAUTER

Filed

1915. *Medical Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 24th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 14th* 1915, to *July 24th* 1915, that I saw him alive on *July 24th* 1915, and that death occurred, on the date stated above, at *10 A. M.*

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) *2* yrs. *10* mos. *10* ds.

CONTRIBUTORY (Secondary)

(Duration) *2* yrs. *10* mos. *10* ds.

(Signed) *R. A. McClure* M. D.*July 24th*, 1915. (Address) *John Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. *10* yrs. *10* mos. *10* ds. In the State *10* yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death? *1*Former or usual residence *Beckville - Maryland*

19-PLACE OF BURIAL OR REMOVAL,

Stanton Va

DATE OF BURIAL,

July 26, 1915

20-UNDERTAKER

Robert C. Fuller

ADDRESS

224 N. Brady

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Grovesse A. Clayton
HEALTH DEPARTMENT—CITY OF BALTIMORE

C86947
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *926* St. *10* WARD)2-FULL NAME *Guinevere Amanda Clayton*(Residence in Baltimore: No. *926* St. *10* WARD)REGISTERED NO. C. *104* C86947

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *3* mos. *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *Col*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *April 1, 1915*

(Month)

(Day)

(Year)

7-AGE, *3* yrs. *24* mos. *24* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Infant*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Eddie Clayton*11-BIRTHPLACE OF FATHER (State or Country), *Penn.*12-MAIDEN NAME OF MOTHER *Elena Henson*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Eddie Clayton*(Address) *926 Ashland Ave*

15-

JUL 25 1915

Filed....., 191.....

ROBERT KRAUTER

Municipal Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 23, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 20, 1915*, to *July 23, 1915*, that I saw her alive on *July 23, 1915*, and that death occurred, on the date stated above, at *4 P. m.*

The CAUSE OF DEATH* was as follows:

Cholera Infantum(Duration)..... yrs. mos. *3* ds.CONTRIBUTORY (Secondary) *Diarrhea*(Duration)..... yrs. mos. *2* ds.(Signed) *J. B. Smith*7/24/15, 1915 (Address) *S. J. Smith*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Laurel C*DATE OF BURIAL, *July 25, 1915*20-UNDERTAKER *Robt A Elliott*ADDRESS *506 East St*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 W. Biddle ST.; 11 WARD)

REGISTERED NO. C

2-FULL NAME Cesator Watts(Residence in Baltimore: No. 334 W. Biddle St.; 9 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

Col.

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

1904

(Month)

(Day)

(Year)

7-AGE,

11

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Child

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

MD.

10-NAME OF FATHER,

D. Watts

11-BIRTHPLACE

OF FATHER

MD.

12-MAIDEN NAME

OF MOTHER

Susan Kelly

13-BIRTHPLACE

OF MOTHER

MD.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Abraham Bishop
334 W. Biddle St.

15-

JUL 25 1915

ROBERT . KRAUTER,

Marital Permit Clerk

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

7/231915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

June 18 1915, to 7/23 1915that I saw him alive on 7/22 1915and that death occurred, on the date stated above, 3:30 p.m.

The CAUSE OF DEATH* was as follows:

PneumoniaAge 1

CONTRIBUTORY

(Secondary)

Age 1(Signed) St. Louis M. D.7/24, 1915, (Address) 724 North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mechanicsville Md.July 26, 1915

20-UNDERTAKER

ADDRESS

Ediz B. Oye102 E. Mulberry

Cause of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 N. Monroe ST. 16 WARD)2-FULL NAME Thomas S. Abbott Jr.(Residence in Baltimore: No. 620 N. Monroe St.; 1 yrs., 7 mos., 7 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) Single

6-DATE OF BIRTH,

Dec 4, 1913
(Month) (Day) (Year)

7-AGE,

1 yrs., 7 mos., 19 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Child9-BIRTHPLACE,
(State or Country),Batts

10-NAME OF FATHER,

Thomas S. Abbott11-BIRTHPLACE OF FATHER
(State or Country),md

12-MAIDEN NAME OF MOTHER

Irene Gannell13-BIRTHPLACE OF MOTHER
(State or Country),Mo

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas S. Abbott Jr.(Address) 620 N. Monroe15- JUL 25 1915 ROBERT . KRAUTER,
Filed..... 191..... Serial. Permit. Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 23, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
July 3 1915, to July 23 1915,
that I saw him alive on July 23 1915,
and that death occurred on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:Cerebral Spinal Meningitis
(Duration)..... yrs..... mos. 20 ds.CONTRIBUTORY..... Cholera
(Secondary)(Signed)..... Harbert E. Jeph. M. D.
July 24, 1915 (Address)..... 205 S. W. 11th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

Western View

DATE OF BURIAL.

July 25, 1915

20-undertaker

Wm Cook

ADDRESS

5026 Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *25 N. Eden*)

2-FULL NAME

(Residence in Baltimore: No. *25 N. Eden*)

REGISTERED No. C

ST.: *5* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: — yrs., — mos. *21* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June

(Month)

25

(Day)

1915

(Year)

7-AGE,

yrs. *1* mos. *21* ds.

If LESS than 1 day.

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE,
(State or Country),*Maryland Balto.*

10-NAME OF FATHER,

*Morris Hyman*11-BIRTHPLACE OF FATHER
(State or Country),*Russia*

12-MAIDEN NAME OF MOTHER

*Mollie Itakovsky*13-BIRTHPLACE OF MOTHER
(State or Country),*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Bessie Itakovsky*(Address) *25 N. Eden St.*

15-

JUL 25 1915

ROBERT . ZRAUTER,

Filed..... 191..... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

(Month)

25

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 25

1915

July 25

1915

that I saw him alive on *July 25*

1915

and that death occurred, on the date stated above, at *12.25 A.M.*

m.

The CAUSE OF DEATH* was as follows:

Acute Colitis(Duration) yrs. *1* mos. *21* ds.CONTRIBUTORY
(Secondary)*Marasmus*(Duration) yrs. *1* mos. *21* ds.(Signed) *Isaac M. Marks*

M. D.

July 25

1915

(Address) *1802 E Baltimore St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Hebrew Mt. Cemetery

DATE OF BURIAL

July 25

1915

20-UNDERTAKER

Isaac M. Marks

ADDRESS

1107 E Balto St

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be stated EXACTLY. PHYSICIANS should
TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *436 Somerset*)

2-FULL NAME *Alfred A. Mitchell*

(Residence in Baltimore: No. *436 Somerset*)

REGISTERED NO. C. *28*

(If death occurred in a hospital or institution, give its NAME instead of street and number and R.R. out No. 18.)

St. *52* yrs. *5* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

colored

5-SINGLE

MARRIED *married*

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

September 1863
(Month) (Day) (Year)

7-AGE

52 yrs. *—* mos. *—* ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer
Plasterer
and white working

9-BIRTHPLACE (State or country)

Maryland

10-NAME OF FATHER

John W. Mitchell

11-BIRTHPLACE OF FATHER (State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Amelia Blake

13-BIRTHPLACE OF MOTHER (State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alfred Mitchell
(Address) *436 Somerset St.*

15-

JUL 25 1915

ROBERT . KRAUTH;

Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 10, 1915*, to, *July 22, 1915*, that I saw him alive on *July 22, 1915*, and that death occurred, on the date stated above, at *5A* m.

The CAUSE OF DEATH* was as follows:

Pul Tuberculosis

Contributory (SECONDARY)

Pul Hemorrhage (Duration) yrs. *1* mos. *12* ds.

(Signed)

W. H. Harris M. D.
July 24, 1915 [Address] *1416 Jefferson St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. *—* mos. *—* ds. In the State, yrs. *—* mos. *—* ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Asbury Cemetery

DATE OF BURIAL

July 25, 1915

ADDRESS

Chas. G. Bailey 1421 Jefferson St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *700 George*ST.; *17* WARD)152
REGISTERED NO. C2-FULL NAME *Baby of David & Katie Greenbaum*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *700 George st*St.; *14* yrs. *14* mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED, *single*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 24, 1915
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,

1 1/4 hrs. or *14* min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work..... *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),*Balto Md.*

10-NAME OF FATHER,

*David Greenbaum*11-BIRTHPLACE OF FATHER
(State or Country),*England.*

12-MAIDEN NAME OF MOTHER

*Katie Polman*13-BIRTHPLACE OF MOTHER
(State or Country),*Balto Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *David Greenbaum*(Address) *700 George st*

15-

JUL 25 1915

ROBERT . KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 25, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 24 191*5*, to *July 25* 191*5*,that I saw him alive on *July 24* 191*5*,and that death occurred, on the date stated above, at *3 1/2* m.

The CAUSE OF DEATH* was as follows:

Primary Atelectasis(Duration) *1* yrs. *1* mos. *1* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. *1* mos. *1* ds.(Signed) *J. S. Hipe* M. D.*July 25, 1915* (Address) *700 George st*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Green Mt Carmel**July 25, 1915*

20-UNDERTAKER

ADDRESS *1107 E**J. Leonard Pro Balto*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2544 Boyd St. ST. 20 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 2544 Boyd St. St.; 28 yrs., 10 mos., 25 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
(Write the word.)

6-DATE OF BIRTH, Aug 29, 1886
(Month) (Day) (Year)

7-AGE, 28 yrs., 10 mos., 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, House Work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto, Md

10-NAME OF FATHER, Michael J. Bach
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER May E. Linder
13-BIRTHPLACE OF MOTHER (State or Country), Phila, Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Bach
(Address) 2544 Boyd St

15- JUL 25 1915 ROBERT J. KRAUTERFiled..... 191... Murial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 9 1914 to July 24 1915, that I saw her alive on July 23 1915, and that death occurred, on the date stated above, at 7:00 m. The CAUSE OF DEATH* was as follows:

Arterio Sclerotic of Heart
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Chronic Intestinal Catarrh
(Duration)..... yrs..... mos..... ds.
(Signed) John A. ... M. D.
July 24 1915 (Address) 1003 ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. mos. ds. In the Life State ... yrs. mos. ds.

Where was disease contracted, if not at place of death? yes

Former or usual residence 2544 Boyd St

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Western Cemetery July 26 1915

20-UNDERTAKER ADDRESS Geo. L. Schwal & Bro 7101 ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 N. Gilmore ST. 19 WARD)

2-FULL NAME

Francis Henry Condon

(Residence ~~106 N. Gilmore~~ No. Powson, Md.

St. 19 yrs. 9 mos. 9 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

January

29

1915

7-AGE

5

26

If LESS than 1 day, hrs. min.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Balto.

10-NAME OF FATHER

Albert F. Condon

11-BIRTHPLACE OF FATHER
(State or country)

Balto.

12-MAIDEN NAME OF MOTHER

Minnie L. Ensey

13-BIRTHPLACE OF MOTHER
(State or country)

Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert F. Condon
Powson, Md.

(Address)

ROBERT A. KRAUTER,

MARITAL PERMIT CLOCK

REGISTRAR

15-

Filed

JUL 25 1915

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I attended deceased from

July 23, 1915 to July 23, 1915,

that I saw him alive on July 23, 1915,

and that death occurred, on the date stated above, at 4:45 p.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea + Enteritis

(Duration) X yrs. 1 mos. 3 ds.

Contributory
(SECONDARY)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed),

C. S. Dickey M. D.

July 23, 1915 [Address] 14 N. Monroe St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

July 25, 1915

20-UNDERTAKER

A. Jones

ADDRESS

207 S. Tucker St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3407 Cedar Ave. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 3407 Cedar

St.; 6 yrs., 6 mos. 7 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) Single

6-DATE OF BIRTH,

7 5, 1915
(Month) (Day) (Year)

7-AGE,

19
yrs. mos. ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Maryland Balto.

10-NAME OF FATHER,

Geo. Marsh

11-BIRTHPLACE OF FATHER
(State or Country),

Balt. Md.

12-MAIDEN NAME OF MOTHER

Mary Seimms

13-BIRTHPLACE OF MOTHER
(State or Country),

Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Marsh

(Address) 3407 Cedar

15-

JUL 25 1915

Filed 191

ROBERT KRAUTER

Bureau Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

7 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

7-5 1915, to 7-24 1915,

that I saw him alive on 7-23 1915,

and that death occurred, on the date stated above, at 2 P. m.

THE CAUSE OF DEATH* was as follows:

Premature Birth

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. 19 ds.

(Signed) J. F. Gough M. D.

2-24 1915 (Address) 3701 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Marys Hospital

July 28 1915

20-UNDERTAKER

ADDRESS

Chenoweth & Son

Chestnut

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *738 Mc Henry*)ST.: *21* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Franklin A. Dixon(Residence in Baltimore: No. *738 Mc Henry*)St.: *32* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Dec - 10, 1844
(Month) (Day) (Year)

7-AGE.

70 yrs., *7* mos., *13* ds.10 LESS (than 1 day).
...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Retired Clerk office*9-BIRTHPLACE.
(State or Country).*Md -*

10-NAME OF FATHER.

*Joshua Dixon*11-BIRTHPLACE OF FATHER.
(State or Country).*Md*

12-MAIDEN NAME OF MOTHER.

*Mary Mealey*13-BIRTHPLACE OF MOTHER.
(State or Country).*Md -*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Emma Lease*(Address) *738 Mc Henry St*

15-

JUL 25 1915 ROBERT . KRASTER,
Filed. for Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 25, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 1915* to *July 23 1915* that I saw him alive on *July 23 1915* and that death occurred, on the date stated above, at *11:30 P.M.* The CAUSE OF DEATH* was as follows:*Pulmonary Tuberculosis*
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY.
(Secondary)*Hypertension* (Duration) ... yrs. ... mos. ... ds.
(Signed) *M. L. Cunningham* M. D.
July 25 1915 (Address) *326 N. Carrollton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Central Cemetery Fred. Co. July 25, 1915

20-UNDERTAKER.

ADDRESS

W. J. Dickerson *Emma Rath*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

86957

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

81 86957
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1806 Guilford Ave.* *12th* WARD)

2-FULL NAME

Mary Ann Burgess

(Residence in Baltimore: No. *1806 Guilford Ave.* *71* yrs. *6* mos. *24* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *female* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *widowed*
(Write the word)

6-DATE OF BIRTH *December 31st, 1843*
(Month) (Day) (Year)

7-AGE *71* yrs. *6* mos. *24* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Balto. Md. U.S.A.*

PARENTS
10-NAME OF FATHER *John O'Loughlin*
11-BIRTHPLACE OF FATHER (State or country) *Balto. Md. U.S.A.*
12-MAIDEN NAME OF MOTHER *Sarah Rust*
13-BIRTHPLACE OF MOTHER (State or country) *Balto. Md. U.S.A.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mrs. J. Weedy Kerr*
(Address) *1806 Guilford Ave.*

15 JUL 25 1915. *ROBERT J. KRAUTER,*
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 24th, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY. That I attended deceased from *Feb.*, 1915, to *July 24*, 1915, that I saw her alive on *July 12th*, 1915, and that death occurred, on the date stated above, at *2:15 A.m.* The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

(Duration) *10* yrs. *-* mos. *-* ds.
Contributory *Acute Pulmonary Oedema*
(SECONDARY)
(Duration) *-* yrs. *-* mos. *1* ds.
(Signed) *Gustavus C. Bohme, M.D.*
July 24, 1915 (Address) *3014 St. Paul St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death *-* yrs. *-* mos. *-* ds. In the State *-* yrs. *-* mos. *-* ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Greenmount Cem.* DATE OF BURIAL *July 26, 1915*
20-UNDERTAKER *Chas. E. Spangh* ADDRESS *802 Madison Ave.*

ADDRESS

NAME - UNDERTAKER	ADDRESS
Chas. J. Evans & Son	118 W. 1st St. & 1st Ave.

Minnie Halbretter HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hosp

ST.;

7

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME

Minnie Halbretter

(Residence in Baltimore: No.

Johns Hopkins Hosp

St.;

yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

April

13

(Month)

(Day)

1872

7-AGE,

43

yrs.

3

mos.

17

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

W. Va.

PARENTS.

10-NAME OF FATHER,

Henry Bolyard

11-BIRTHPLACE OF FATHER

(State or Country),

W. Va.

12-MAIDEN NAME OF MOTHER

Nancy Sigley

13-BIRTHPLACE OF MOTHER

(State or Country),

W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

A. J. Smith

(Address).....

Johns Hopkins Hospital

15-

Filed

JUL 25 1915

ROBERT KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

(Month)

25

(Day)

1915

(Year)

I HEREBY CERTIFY, That I attended deceased from

July 19

1915,

to July 25

1915,

that I saw her alive on

July 25th

1915,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism, post-mortem
 following hysterectomy, appendectomy,
 cholecystomy, proctitis, and fornication.

(Duration).....

yrs.

mos.

6 ds.

CONTRIBUTORY (Secondary)

(Duration).....

yrs.

mos.

ds.

(Signed).....

H. M. D.

J. M. D.

M. D.

7/25

1915

(Address).....

Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

of death

yrs.

mos.

6 ds.

In the

State

yrs.

mos.

6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Immigrant

W. Va.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Immigrant W. Va.

July 26

1915.

20-UNDERTAKER

ADDRESS

Alfred C. Miller

221 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf't Asy.* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Inf'ant Asylum* St.; yrs. *7* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

Nov
(Month)*23*
(Day)*1914*
(Year)

7-AGE,

yrs. *8* mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St*

15-

Filed *JUL 25 1915* *ROBERT KRAUTER*
Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July
(Month)*24*
(Day)*1915*
(Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1st* 1915, to *July 23* 1915, that I saw her alive on *July 23* 1915, and that death occurred, on the date stated above, at *12:06* m.

The CAUSE OF DEATH* was as follows:

Malnutrition and Mal-assimilation(Duration) yrs. *2* mos. ds.CONTRIBUTORY... *Tuberculosis*
(Secondary)(Duration) yrs. *1* mos. ds.(Signed) *J. E. Poulson* M. D.*July 24* 1915. (Address) *615 Columbia Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *7* mos. ds. In the State yrs. *8* mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Cathedral *July 26 1915*

20-UNDERTAKER

ADDRESS

Ch. Fahy & Sons 606 Lafayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Married girl* REGISTERED NO. C
 CITY OF BALTIMORE: (NO. *402* ST.; *Bel* WARD)
 2-FULL NAME *Enora Hill*
 (Residence in Baltimore: No. *402* St.; *3* yrs., *3* mos., *13* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *Black* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
 6-DATE OF BIRTH. *Mar. 12, 1896*
 (Month) (Day) (Year)
 7-AGE. *19* yrs., *4* mos., *13* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Private family*
 (b) General nature of industry, business, or establishment in which employed (or employer). *House Keeper*

9-BIRTHPLACE, (State or Country). *Maryland*

10-NAME OF FATHER. *Mr. H. Hill*

11-BIRTHPLACE OF FATHER (State or Country). *md.*

12-MAIDEN NAME OF MOTHER *Annie V. Estep*

13-BIRTHPLACE OF MOTHER (State or Country). *md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sarah Armstrong*
 (Address) *402 Bell St.*

15- JUL 26 1915
 Filed..... 1915 Serial *1015* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *July 25, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 12, 1915*, to *July 25, 1915*, that I saw her alive on *July 24, 1915*, and that death occurred, on the date stated above, at *6:42 a.m.* The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis
Meningitis
 (Duration) yrs. mos. *18* ds.

CONTRIBUTORY (Secondary) *Tb Peritonitis*

(Duration) yrs. mos. *18* ds.
 (Signed) *C. W. Myers* M. D.
July 25, 1915 (Address) *2nd girl St. 1st*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *13* ds. In the *3* yrs. mos. ds. State

Where was disease contracted, if not at place of death? *?*

Former or usual residence *402 Bell St.*

19-PLACE OF BURIAL OR REMOVAL, and DATE OF BURIAL.

McKendrick & Co *July 26, 1915*

20-UNDERTAKER ADDRESS *C. A. Wiedefeld*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 520 Dover

FULL NAME

(Residence in Baltimore: No. 520 Dover

ST. 22 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX,

male

COLOR OR RACE,

Coe

SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

Single

DATE OF BIRTH,

Mar 10, 1869

AGE,

44 yrs. 4 mos. 14 ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer
Oyster House

BIRTHPLACE,

(State or Country),

Balto

NAME OF FATHER,

Bas Welford

BIRTHPLACE OF FATHER

(State or Country),

Maryland

MAIDEN NAME OF MOTHER

May E Brooks

BIRTHPLACE OF MOTHER

(State or Country),

Balto

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

May E Brooks
520 Dover

15-

JUL 26 1915

HARRY O. ANDREWS

Marial Port...

CORONER'S CERTIFICATE OF DEATH.

DATE OF DEATH,

July 24, 1915

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

uremia

CONTRIBUTORY (Secondary)

Chr hepatitis

(Signed)

July 24, 1915

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL,

Ant Auburn Contag

DATE OF BURIAL,

July 26, 1915

UNDERTAKER

Wes H Hooper

ADDRESS

107 Little Rock St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *756 Daphin* ST.; *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Annie Mary Hall*(Residence in Baltimore: No. *756 Daphin* St.; *—* yrs., *—* mos., *—* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, *Married**Widowed*
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *August 18, 1880*

(Month)

(Day)

(Year)

7-AGE, *70* yrs., *11* mos., *9* da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Samuel Hall*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER, *Mary O'Brien*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harold S. Andrews*(Address) *701 N. Carrollton Ave.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 23rd, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Nurses* 191*3*, to *July 23rd* 191*5*, that I saw her alive on *July 23rd* 191*5*, and that death occurred, on the date stated above, at *10:58 P.* m.

The CAUSE OF DEATH* was as follows:

Coronary Hypertrophy(Duration) *3* yrs., *—* mos., *—* da.CONTRIBUTORY (Secondary) *Intermittent Hypertension*(Duration) *3* yrs., *—* mos., *—* da.(Signed) *Harold S. Andrews* M. D......, 191... (Address) *701 N. Carrollton Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park Cemetery*DATE OF BURIAL, *July 26, 1915*20-UNDERTAKER, *Everett Mitchell & Co., 2011 Myrtle St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15-

JUL 26 1915

HARRY O. ANDREWS,

Filed

151

Marital Permit

Registrar

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86965

HEALTH DEPARTMENT-CITY OF BALTIMORE
CERTIFICATE OF DEATH

C86965

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1821 N Register

2-FULL NAME

(Residence in Baltimore: No. 1821 N Register

Anna Elizabeth Scherer

1821 N Register

REGISTERED NO. C

ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str. 75 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widow

6 DATE OF BIRTH

Sept

7 AGE

75

(Month)

13, 1838

(Day)

(Year)

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Balti City

10 NAME OF FATHER

John Jacob Bregel

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Philip H Scherer

(Address)

1821 N Register

JUL 26 1915

Filed

HARRY V. ANDREWS,

Barial Permit Clerk,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

25, 1915

17

I HEREBY CERTIFY. That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at 9 45 m.

The CAUSE OF DEATH* was as follows:

Toxemia

Contributory (SECONDARY)

(Duration)

yrs. mos. ds. 2

(Signed)

John T Spickard

(Duration)

yrs. mos. ds. 2

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London Park Cem

7/27/15

Chas F Edwards

1481 N Royal

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *428 N. Port*)

2-FULL NAME *Joseph W. Bantz*

(Residence in Baltimore: No. *428 N. Port*)

REGISTERED NO. C

ST. *6* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6-DATE OF BIRTH

December 27, 1914
(Month) (Day) (Year)

7-AGE

6 yrs. *27* mos. *27* ds. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Md

10-NAME OF FATHER

Earl B. Bantz

11-BIRTHPLACE OF FATHER
(State or country)

Md

12-MAIDEN NAME OF MOTHER

Mary Cooksey

13-BIRTHPLACE OF MOTHER
(State or country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Bantz
428 N. Port St
(Address)

15-

JUL 26 1915

CHARLES O. ANDERSON
Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 24, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 23, 1915 to *July 24, 1915*

that I saw her alive on *July 23, 1915*

and that death occurred, on the date stated above, at *2 am* m.

The CAUSE OF DEATH* was as follows:

Brancho Pneumonia

Contributory (SECONDARY)

(Duration) yrs. mos. *2* ds.

(Signed)

J. A. Insley M. D.
July 24, 1915 (Address) *2138 C St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Carmel Cemetery July 26, 1915

20-UNDERTAKER

ADDRESS

Christian Miller 233 Jefferson

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86962

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1743 Fleet ST. 2 WARD)

REGISTERED NO. C

2-FULL NAME

Anthony Pedersen

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1743 Fleet St St. 20 yrs. 9 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH,

Oct 21st, 1871
(Month) (Day) (Year)

7-AGE,

43 yrs. 9 mos. 2 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Mariner
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Norway

10-NAME OF FATHER,

Andrew Pedersen

11-BIRTHPLACE OF FATHER (State or Country),

Norway

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER (State or Country),

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Pedersen

(Address) 1743 Fleet St

15-

JUL 26 1915

HARRY O. ANDERSON

Filed Jul 26 1915 Serial Permit 010

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 23, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 3 1915, to July 23 1915, that I saw him alive on July 22 1915, and that death occurred, on the date stated above, at 3³⁰ A. M.

The CAUSE OF DEATH* was as follows:

Enteric Fever -

(Duration) 3 1/2 wks. -

CONTRIBUTORY (Secondary)

Septic -

(Duration) 10 yrs. 10 mos. 10 ds.

(Signed) Thos. J. Jones M. D.

July 24, 1915. (Address) 125 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 yrs. 10 mos. 10 ds. In the State 10 yrs. 10 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Trinity Cemetery July 26, 1915.

20-UNDERTAKER

ADDRESS

J. Sander & Sons 1743 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *121 E Ostrud* St.; *24th* WARD)

2-FULL NAME

William F Sullivan(Residence in Baltimore: No. *121 E Ostrud* St.; *24th* yrs., *7* mos., *7* da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH.

June 30th, 1869
(Month) (Day) (Year)

7-AGE.

46 yrs., 0 mos., 26 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Labour*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country).

Florida

10-NAME OF FATHER.

John F Sullivan

11-BIRTHPLACE OF FATHER (State or Country).

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country).

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jennie Sullivan*(Address) *121 E Ostrud St*

15-

JUL 26 1915. HARRY O. ADAMS, Registrar.
Filed..... 191. Serial Permit 01074

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 25th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *March 15* 1915, to *July 25* 1915, that I saw him alive on *July 25* 1915, and that death occurred, on the date stated above, at *9 a. m.*

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart(Duration) *7 1/2* yrs. *2* mos. *2* ds.CONTRIBUTORY (Secondary) *Acute dilatation*(Duration) *4* yrs. *4* mos. *4* ds.(Signed) *Wm. H. H. H.* M. D.*July 26, 1915.* (Address) *1274 William St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Mrs. Oliver

DATE OF BURIAL.

July 28, 1915.

20-UNDERTAKER

E and B Harle

ADDRESS

15 E West St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *10* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

David Drann(Residence in Baltimore: No. *832 Asquith St*St.; *7* yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED, *single*
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

June 4

(Month)

(Day)

1908
(Year)

7-AGE,

7

yrs.

1

mos.

21

ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.*none*(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).

9-BIRTHPLACE,

(State or Country),

*md.*10-NAME OF
FATHER,*Sam Drann*11-BIRTHPLACE
OF FATHER

(State or Country),

*Russia*12-MAIDEN NAME
OF MOTHER*Ida Artwell*13-BIRTHPLACE
OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

A. J. Smith

(Address)

Johns Hopkins Hospital

15-

JUL 26 1915

HARRY O. ANDREWS,

1931-1932 Permitted Clerk,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

(Month)

25

(Day)

1915
(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 3

1915, to

July 25

1915,

that I saw him alive on *July 25* 1915,and that death occurred, on the date stated above, at *1:10 p.m.*

The CAUSE OF DEATH* was as follows:

Post-diphtheritic paralysis(Duration).....yrs.....*1* mos.....*8* ds.CONTRIBUTORY.....*paralysis of respiratory centre*
(Secondary)(Duration).....yrs.....*1* mos.....*8* ds.(Signed).....*A. S. Rothberg*.....M. D.*July 25, 1915.* (Address).....*Johns Hopkins Hosp**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....*22* mos.....*7* ds. In the State.....yrs.....*7* yrs.....*7* mos.....*7* ds.Where was disease contracted,
if not at place of death?Former or usual residence *832 Asquith St*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Heaven Washington D.C. *July 26 1915*

20-UNDERTAKER, ADDRESS

Jack Lewis *1419 E. Pratt**11. 11. 11.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2302 Pennsylvania ave. ST. 15 WARD)

2-FULL NAME Anton Schoedl,

(Residence in Baltimore: No. 2302 Pennsylvania ave.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, Unknown, / (Month) (Day) (Year)

7-AGE, 53 yrs., ? mos., ? da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Tailor, (b) General nature of industry, business, or establishment in which employed (or employer), Mens clothes

9-BIRTHPLACE. (State or Country), Austria,

10-NAME OF FATHER, Unknown,

11-BIRTHPLACE OF FATHER (State or Country), Unknown,

12-MAIDEN NAME OF MOTHER, Unknown,

13-BIRTHPLACE OF MOTHER (State or Country), Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Mary Homberg, neighbor,

(Address)... 2302 Pennsylvania ave.

15- JUL 26 1915, HARRY O. ANDREWS,

Filed, 191... Serial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency and dropsy due probably to chronic Bright's disease, (Duration) yrs., mos., da.

CONTRIBUTORY (Secondary) (Duration) yrs., mos., da.

(Signed) J. Frederick Thompson, M. D. (Coroner.)

July 24 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs., mos., da. In the State... yrs., mos., da.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, July 27, 1915

20-UNDERTAKER, Joseph Syfer ADDRESS, 100 W. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1539 E. Monument St.* WARD *7*)

REGISTERED NO. C

2-FULL NAME

F. Evelyn Leffler

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1539 E. Monument*St.: *16* yrs., *10* mos., *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

single

6-DATE OF BIRTH,

Sept 17, 1898
(Month) (Day) (Year)

7-AGE,

16 yrs., *10* mos., *7* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

school girl

9-BIRTHPLACE,

(State or Country),

Balto. Md.

10-NAME OF FATHER,

Wm. H. Leffler

11-BIRTHPLACE OF FATHER

(State or Country),

Balto

12-MAIDEN NAME OF MOTHER

Florence J. Hanson

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Florence J. Leffler

(Address)

1539 E. Monument

15-

Filed

JUL 26 1915

HARRY O. ANDERSON

Bureau of Vital Statistics

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 27, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 6, 1915, to July 24, 1915,*that I saw her alive on *July 24, 1915,*and that death occurred, on the date stated above, at *1:30 a.m.*

The CAUSE OF DEATH* was as follows:

Typhoid Fever(Duration).....yrs.....mos.....*18* ds.

CONTRIBUTORY

(Secondary)

Pneumonia(Duration).....yrs.....mos.....*4* ds.

(Signed)

*William F. Zimmerman, M. D.**July 27, 1915. (Address) 22 E. Pratt St.*

(State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Brim Ridge Cem July 27, 1915

20-UNDERTAKER

ADDRESS

Wm Cook 102 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1224 N. Central W. 110 ST.)2-FULL NAME Emma Witte(Residence in Baltimore: No. 1224 N. Central Ave St.; 61 yrs. 5 mos. 27 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female4-COLOR OR RACE white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH

Feb (Month) 3 (Day) 1854 (Year)

7-AGE

61 yrs. 5 mos. 27 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) Housewife9-BIRTHPLACE, (State or Country), Md.10-NAME OF FATHER, Henry Stevens11-BIRTHPLACE OF FATHER (State or Country), Md.12-MAIDEN NAME OF MOTHER Luna Wheeler13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Witte(Address) 1224 N. Central Ave

15-

JUL 26 1915

HARRY O. ANDREWS,

Bureau of Health, City of Baltimore,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1915, to July 24 1915, that I saw her alive on July 24 1915, and that death occurred, on the date stated above, at 7:40 a.m. The CAUSE OF DEATH* was as follows:Interstitial Nephritis.(Duration) 4 yrs. 5 mos. 5 ds.CONTRIBUTORY (Secondary) Coma(Duration) 4 yrs. 5 mos. 5 ds.(Signed) Herbert C. Knapp, M.D. (Address) 1216 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, WesternDATE OF BURIAL, July 27, 191520-UNDERTAKER Herbert C. Knapp, M.D.ADDRESS 502 E. Pratt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 John St.)

2-FULL NAME

(Residence in Baltimore: No. 1606 John St.)

REGISTERED NO. C. 28

WARD 14

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

Sept

29th 1855

7-AGE

59 yrs. 10 mos. 5 ds.

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Grocery Business

9-BIRTHPLACE
(State or country)

md

10-NAME OF FATHER

Benjamin Howard

11-BIRTHPLACE OF FATHER
(State or country)

md

12-MAIDEN NAME OF MOTHER

Ann Wright

13-BIRTHPLACE OF MOTHER
(State or country)

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Howard

(Address)

1606 John St

15-JUL 26 1915

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July

24

1915

17- I HEREBY CERTIFY, That I attended deceased from

June 1914, to July 24 1915,

that I saw him alive on July 23 1915,

and that death occurred, on the date stated above, at 2:11 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(Duration) 1 yrs 10 mos ds.

Contributory
(SECONDARY)

Cardiac valvular disease

(Duration) yrs mos ds.

(Signed)

J. H. [Signature]

July 24 1915 [Address] 9 Lyndale Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lorraine Ave

July 26 1915

20-UNDERTAKER

ADDRESS

G. S. Walker

723 N. [Address]

11. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86974

HEALTH DEPARTMENT--CITY OF BALTIMORE

C86974

CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Reginald P. Sappington
(Residence in Baltimore: No. Old York Road off W. 42nd St. yrs. 5 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE white 5-SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH Lost/known 1869
(Month) (Day) (Year)

7-AGE about 46 yrs. 4 mos. 5 ds. or min.?
If LESS than 1 day, hrs.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Druggist
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Maryland

10-NAME OF FATHER Richard Sappington

11-BIRTHPLACE OF FATHER (State or country) Balto Md

12-MAIDEN NAME OF MOTHER Lost/known

13-BIRTHPLACE OF MOTHER (State or country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles B. Thompson

(Address) Johns Hopkins Hospital

JUL 26 1915
Filed 191 Serial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH July 25 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 20, 1915, to July 25, 1915, that I saw him alive on July 25, 1915, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Psychosis with excitement
and exhaustion
Dementia Praecox

(Duration) 10 yrs. 10 mos. 10 ds.
Contributory Vasomotor Collapse
(SECONDARY) 3 3/4 hrs.
(Duration) 3 3/4 hrs. 3 mos. 3 ds.

(Signed), Charles B. Thompson M. D.
July 25, 1915 [Address] Johns Hopkins Hospital

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 5 yrs. 4 mos. 5 ds. State 46 yrs. 4 mos. 5 ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence Old York Road - Gwynn

19-PLACE OF BURIAL OR REMOVAL Greenmount DATE OF BURIAL July 27, 1915

20-UNDERTAKER William Cook ADDRESS 302 E North

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *504 Oxford* ST.: *17* WARD)

REGISTERED NO. C

2-FULL NAME *Theodore Hedgeman*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *504 Oxford* St.: *24* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*6-DATE OF BIRTH. *1891*

(Month)

(Day)

(Year)

7-AGE *24*

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Porter*(b) General nature of industry, business, or establishment in which employed (or employer). *Bowling alley*9-BIRTHPLACE, (State or Country), *Balt. City*

PARENTS.

10-NAME OF FATHER, *William Hedgeman*11-BIRTHPLACE OF FATHER (State or Country), *Balt. City*12-MAIDEN NAME OF MOTHER *Katie Swell*13-BIRTHPLACE OF MOTHER (State or Country), *Balt. City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Katie Swell*(Address) *504 Oxford St.*

15-

JUL 26 1915

HARRY O. ANDREWS,

Register.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 24th 1915*

(Month)

(Day)

(Year)

I HEREBY CERTIFY That I attended deceased from *July 18th 1915* to *July 24th 1915*, that I saw him alive on *July 18th 1915*, and that death occurred, on the date stated above, at *3* p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

(Signed) *A. L. Ellis* M. D. *7/24/15* (Address) *724 Madison St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Laurel Glen*DATE OF BURIAL, *July 27th 1915*20-UNDERTAKER, *Charles W. Wynn*ADDRESS, *1364 M. Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86976

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: 59 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED, married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....9-BIRTHPLACE,
(State or Country),10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

HARRY O. ANDREWS,

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY. Operation for inguinal Hernia

(Signed) M. B. Brown and H. O. Andrews, M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 12 ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2039 Division*)ST.: *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2039 Division*)St.: yrs. mos. *8 mos.*

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH,

July 24, 1915
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day.

yrs. mos. ds. *8 hrs. or min.*

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Domestic*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

City

10-NAME OF FATHER,

William Rugg

11-BIRTHPLACE OF FATHER (State or Country),

City

12-MAIDEN NAME OF MOTHER

May C. Rugg

13-BIRTHPLACE OF MOTHER (State or Country),

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Rugg*(Address) *2039 Division*

15-

Filed

JUL 26 1915

HARRY O. ANDERSON

Bureau of Health

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 24, 1915 to *July 24, 1915*that I saw her alive on *July 24, 1915* and that death occurred, on the date stated above, at *4:30 P. m.*

The CAUSE OF DEATH* was as follows:

Congenital Metastasis(Duration) yrs. mos. *8 mos.*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. *8 mos.*(Signed) *W. J. Carr, Jr.* M. D.*July 25, 1915* (Address) *515 W. 15th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Ambrose *July 26, 1915*

20-UNDERTAKER

ADDRESS

James D. Wright *364 W. 15th St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1253 W. Cross* ST.; *21* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Matthew Quinn Layton*(Residence in Baltimore: No. *1253 W. Cross* St.; *2* yrs., *2* mos., *26* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *April 26*, 1915 (Month) (Day) (Year)7-AGE, *2* yrs., *26* mos., *26* ds. If LESS than 1 day. hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *none* (b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Balto., Md.*10-NAME OF FATHER, *Francis S. Layton*11-BIRTHPLACE OF FATHER (State or Country), *Balto., Md.*12-MAIDEN NAME OF MOTHER *Frances Quinn*13-BIRTHPLACE OF MOTHER (State or Country), *Balto., Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Matthew Quinn*(Address) *1253 W. Cross St.*15- *JUL 26 1915*Filed..... 191. *Marial. Permit. Clerk* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 24*, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 20*, 1915, to *July 24* 1915, that I saw him alive on *July 24*, 1915,and that death occurred, on the date stated above, at *11-40 A.M.*

The CAUSE OF DEATH* was as follows:

Gastro-enteritis(Duration) *1* yrs., *1* mos., *1* ds.

CONTRIBUTORY (Secondary).....

(Duration) *1* yrs., *1* mos., *1* ds.(Signed) *J. B. Linn* M. D.*July 25* 1915 (Address) *645 Columbia*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

St. Peters Cemetery *July 26*, 1915.

20-UNDERTAKER ADDRESS

D. M. Flynn *1422 Light St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Estelle Oliver*(Residence in Baltimore: No. *Mercy Hospital* St.; yrs. mos. *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Apr. 3, 1889*

(Month)

(Day)

(Year)

7-AGE, *26 3 22*

yrs.

mos.

da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer). *General*9-BIRTHPLACE, (State or Country), *Minn.*10-NAME OF FATHER, *George Eckels*11-BIRTHPLACE OF FATHER (State or Country), *Minn.*12-MAIDEN NAME OF MOTHER *Mildred Ambrose*13-BIRTHPLACE OF MOTHER (State or Country), *Minn.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Charles Oliver *Belair Md* (Informant?)*Belair Md* (Address)15-*JUL 26 1915*

HARRY O. ANDERSON

Filed *1915* *Marital Permit* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 25, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 7, 1915*, to *July 25, 1915*, that I saw her alive on *July 25, 1915*, and that death occurred, on the date stated above, at *5:50 P.M.*

The CAUSE OF DEATH* was as follows:

Child Birth at term, July 19-1915

(Duration)

yrs.

mos.

da.

CONTRIBUTORY (Secondary) *Acute Yellow Atrophy*

(Duration)

yrs.

mos.

da.

(Signed) *Edward P. Smith* M. D.

July 25, 1915

(Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *18* yrs. *10* mos. *10* da. In the *10* yrs. *10* mos. *10* da. StateWhere was disease contracted, if not at place of death? *Belair Md*Former or usual residence *Belair Md*19-PLACE OF BURIAL OR REMOVAL, *New Cathedral Cvn*DATE OF BURIAL, *7-26-1915*20-UNDERTAKER, *Henry W. J. Kimberson Co*ADDRESS *Orchard*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1934 Bank ST.; 2 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1934 Bank St. St.; 30 yrs., — mos., — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE White 5-Single
(Write the word.)6-DATE OF BIRTH Not Known, 1866
(Month) (Day) (Year)7-AGE 49 yrs., — mos., — ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At Home9-BIRTHPLACE, (State or Country), Russian Poland10-NAME OF FATHER, Michael Kobylinski11-BIRTHPLACE OF FATHER (State or Country), Russian Poland12-MAIDEN NAME OF MOTHER Anna Trzebinska13-BIRTHPLACE OF MOTHER (State or Country), Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vincent Galszewski
(Address) 1934 Bank St.15-JUL 26 1915 HARRY O. ARLETT
Filed..... 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from on July 23 1915, to 191,
that I saw her alive on July 23 1915,
and that death occurred, on the date stated above, at 5:50 P.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris
arterio sclerosis
myocarditis
Endocarditis
(Duration) 7 yrs., — mos., — ds.CONTRIBUTORY (Secondary) Angina Pectoris
10 minutes
(Duration) 7 yrs., — mos., — ds.(Signed) Edgar P. Sandrock M. D.
July 25, 1915. (Address) 1601 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Nob. Rosary DATE OF BURIAL, July 27, 191520-UNDERTAKER William Lialowski ADDRESS 1618 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

086981

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

086981

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 228 S. Fremont Ave.)

2 FULL NAME

(Residence in Baltimore: No. 228 S. Fremont Ave.)

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Dec 1, 1913

7 AGE

1 yrs. 7 mos. 16 ds. or min. 7

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

Baltimore Md

10 NAME OF FATHER

James G. Cole

11 BIRTHPLACE OF FATHER (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Violet McKay

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Violet Cole

(Address)

228 S. Fremont Ave.

JUL 26 1915

Filed

HARRY O. ANDERSON,

Sanial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 23, 1915

17 I HEREBY CERTIFY, That I attended deceased from

July 12, 1915, to, July 23, 1915.

that I saw him alive on July 23, 1915.

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Acute Colitis

(Duration) yrs. mos. 12 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) R. C. Mehel M. D.

July 24, 1915 (Address) 1903 W. North St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Lenox Park

DATE OF BURIAL

July 26, 1915

20 UNDERTAKER

Reid S. Luman 1442 N. Bldg.

THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88982

88982

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

Str.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX ~~Male~~ 4 COLOR OR RACE ~~White~~ 5 SINGLE ~~Married~~
6 DATE OF BIRTH July 17, 1847
(Month) (Day) (Year)

16 DATE OF DEATH July 25, 1915
(Month) (Day) (Year)

7 AGE 67 yrs. 8 mos. 8 ds. 89 If LESS than 1 day, hrs. or min.?

17 I, THEREBY CERTIFY, That I attended deceased from July 3, 1915, to July 25, 1915

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employee): Painter

that I saw him alive on July 3, 1915, and that death occurred, on the date stated above, at 5:30 p. m. The CAUSE OF DEATH* was as follows:

9 BIRTHPLACE (State or country)

Myocardial Degeneration
(Duration) yrs. mos. ds.

10 NAME OF FATHER

Contributory (SECONDARY) Extensive Splenomegaly
(Duration) yrs. mos. ds.

11 BIRTHPLACE OF FATHER (State or country)

(Signed) George A. Hartman, M. D.
July 26, 1915 (Address) 1131 7th Avenue St.

12 MAIDEN NAME OF MOTHER

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

13 BIRTHPLACE OF MOTHER (State or country)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death yrs. mos. ds. In the State yrs. mos. ds.

(Informant) E. Lewis Witz
(Address) 1522 E. Preston

Where was disease contracted? If not at place of death? Former or usual residence

15 JUL 26 1915
HARRY O. ANDERSON,
Serial Permit Clerk,
REGISTRAR

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

London Park July 28, 1915
Address
Rev. J. J. Jones 1842 7th Bldg

Martin Baronowski HEALTH DEPARTMENT—CITY OF BALTIMORE

C86983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *727 S. Broadway* ST. *2* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Martin Baronowski*(Residence in Baltimore: No. *727 S. Broadway* St.; *24* yrs., *3* mos., *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male*4-COLOR OR RACE, *white*5-SINGLE, *married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *November, 1866*

(Month)

(Day)

(Year)

7-AGE, *49* yrs., *3* mos., *-* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Restaurant*(b) General nature of industry, business, or establishment in which employed (or employer) *Retired*9-BIRTHPLACE,
(State or Country), *Germany*10-NAME OF FATHER, *John Baronowski*11-BIRTHPLACE OF FATHER
(State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Not known*13-BIRTHPLACE OF MOTHER
(State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Martin Baronowski*(Address) *727 S. Broadway*

JUL 26 1915

Filed....., 191.

Parmit Olorik
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 27, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *191*, to *191*,that I saw h..... alive on *191*,and that death occurred, on the date stated above, at *191* m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *St. Stanislaus*DATE OF BURIAL, *July 27, 1915*20-UNDERTAKER *M. J. Sadowski*ADDRESS *705 S. Conn St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86984

CERTIFICATE OF DEATH.

x104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital

ST.:

7

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Joy Richards

(Residence in Baltimore: No.

38131 Fernwood Ave.

St.; life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH.

September 5th 1914, 1914.
(Month) (Day) (Year)

7-AGE.

10 yrs., 10 mos., 16 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country)

Balto. Maryland

10-NAME OF FATHER.

F. T. Richards

11-BIRTHPLACE OF FATHER
(State or Country).

Pennsylvania

12-MAIDEN NAME OF MOTHER

Bertha Davis

13-BIRTHPLACE OF MOTHER
(State or Country).

Wilmington - Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

P. Roszel

(Address).....

Johns Hopkins Hospital

15-

JUL 26 1915

Baltimore, Md.

Burial Permit Order

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 24th 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21st 1915, to July 24th 1915, that I saw him alive on July 24th 1915, and that death occurred, on the date stated above, at 3:35 p.m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

July 24th 1915. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 3813 Fernwood Ave

19-PLACE OF BURIAL OR REMOVAL.

Oaklawn

DATE OF BURIAL.

July 27, 1915.

20-UNDERTAKER

Zirkler and Zirkler

ADDRESS 1739

E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 2 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUL 26 1915

191

BARRY C. ANDERSON Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

July 21 1915, to July 25 1915,

that I saw her alive on July 25 1915,

and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

(Signed) Geo. Heuser

M. D.

7-26-1915 (Address) 1937 Gough St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Emanuel Louis & Hermann 32 S. Broad.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, MD.

ST.

WARD

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs.; mos. 9 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Oct. 29, 1854

(Month)

(Day)

(Year)

7-AGE,

60 yrs. 8 mos. 25 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Farmer

9-BIRTHPLACE,

(State or Country),

W. Va.

10-NAME OF FATHER,

John Stalvaker

11-BIRTHPLACE OF FATHER

(State or Country),

W. Va.

12-MAIDEN NAME OF MOTHER

Sarah Becker

13-BIRTHPLACE OF MOTHER

(State or Country),

W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUL 26 1915

ROBERT

KRAUTER,

Filed

191

Burial

Permit. Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 24, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 15, 1915, to July 24, 1915,

that I saw him alive on July 24, 1915,

and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

(Primary) Post-tubercular
 (Secondary) Pneumonia
 about 12 mos.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward J. Smith M. D.

July 24, 1915 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Froy W. Va.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Weston, W. Va.

7/26, 1915.

20-UNDERTAKER

ADDRESS

Henry W. Meade & Am

805 N. Calver

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86987

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86987

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *700 W. Lombard*) ST. *4* WARD
2-FULL NAME *Mary S. Price*
(Residence in Baltimore: No. *700 W. Lombard St.*)
REGISTERED NO. C *59*
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)
St.; yrs. *20* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Female</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) <i>Single</i>
6-DATE OF BIRTH <i>Aug 1888</i> (Month) (Day) (Year)		
7-AGE <i>34</i> yrs. 7 mos. 7 ds. If LESS than 1 day, ...hrs. or...min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <i>Piano teacher</i>		
9-BIRTHPLACE, (State or Country), <i>Rochester, N. York</i>		
PARENTS.	10-NAME OF FATHER, <i>Unknown</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Unknown</i>	
	12-MAIDEN NAME OF MOTHER <i>Unknown</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Unknown</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. E. H. Kaidzo*
(Address) *Hamilton Bldg 60*

15-
JUL 26 1915
ROBERT KRAUTER
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH
July 25th, 1915.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*
(Inquest, au-

inquest and that said deceased came to *her* death
(top, or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Morphine Poisoning

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Moam Savary* M. D.
(Coroner.)

July 26 1915 (Address) *1729 N. Guilford St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Longview *July 26 1915*

20-UNDERTAKER ADDRESS

Mrs. F. H. Jones *138 Regt St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 W West ST.; 23 WARD)

FULL NAME James Mannion

(Residence in Baltimore, No. 106 W West St.; 50 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widowed

6-DATE OF BIRTH,

September, 1852

(Month)

(Day)

(Year)

7-AGE,

53

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE,

(State or Country).

St. Louis, Mo.

10-NAME OF FATHER,

James Mannion

11-BIRTHPLACE OF FATHER

(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Mary Flynn

13-BIRTHPLACE OF MOTHER

(State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

1423 Light St.

15-

JUL 26 1915

Filed..... 191.....

ROBERT . KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 24, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from July 20 1915, to July 24 1915, that I saw him alive on July 24 1915, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. P. Campbell M. D.

July 24 1915 (Address) 1684 Hancock St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery, July 27 1915

20-UNDERTAKER

ADDRESS

J. P. Campbell 318 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2204 Ashland Ave* St. *7* WARD)

2-FULL NAME

Peter D. Hederman(Residence in Baltimore: No. *2204 Ashland Ave* St. *7* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARKED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 28, 1836
(Month) (Day) (Year)

7-AGE,

79 yrs. *3* mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Retired Baker*9-BIRTHPLACE,
(State or Country),*Ireland*

10-NAME OF FATHER,

Joe. Hederman

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Annie DeLaurder*(Address) *2204 Ashland Ave*

15-

JUL 26 1915

ROBERT . KRAUTER,

Filed. 1915. Burial Permit. Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 21 1915, to *July 24* 1915that I saw him alive on *July 24* 1915,and that death occurred, on the date stated above, at *5 P* m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(base with lungs)(Duration) yrs. mos. ds. *2*CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. J. Stewart* M. D.*7/26*, 1915. (Address) *838 E. Preston*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral *July 27* 1915

20-UNDERTAKER

ADDRESS

Geo M. Fink *811 N. W. 8th*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C86990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

C86990

1. PLACE OF DEATH

CITY OF BALTIMORE (No.

Hill & Brane

ST. *9* WARD)

2. FULL NAME

Margaret Flanagan

(Residence in Baltimore: No.

512 - 23rd St

St. *47* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word)

6. DATE OF BIRTH *Nov 20, 1847*
(Month) (Day) (Year)

7. AGE *67* yrs. *8* mos. *3* ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country) *Ireland*

10. NAME OF FATHER *Thos Sharkey*

11. BIRTHPLACE OF FATHER (State or country) *Ireland*

12. MAIDEN NAME OF MOTHER *Catherine Kelly*

13. BIRTHPLACE OF MOTHER (State or country) *Ireland*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Margaret Beatty*
(Address) *Hill & Brane*

15. *JUL 26 1915* *ROBERT J. KRAUTER,*
Funeral Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *July 23, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 13, 1915*, to *July 23, 1915*, that I saw her alive on *July 23, 1915*, and that death occurred, on the date stated above, at *7 P.* m. The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Contributory (SECONDARY) *Cardiac Insufficiency* (Duration) *2* yrs. mos. ds.
(Signed) *Thos. A. Schaefer* M. D. *July 23, 1915* (Address) *2508 W. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Lexas Balto Co* DATE OF BURIAL *July 27, 1915*

20. UNDERTAKER *C. A. Wiedefeld*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86991

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-STATUS

(Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

JUL 26 1915

Filed.....

ROBERT . KRAUTER,

1914
Mortuary Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

May 23 1915, to July 26 1915.

that I saw her alive on July 24 1915.

and that death occurred, on the date stated above, at 4:50 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 14 mos. ds.

(Signed) J. H. Hughes M. D.

July 26 1915 (Address) 1413 S. Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Probus, Va

July 28 1915

20-UNDERTAKER

ADDRESS 517

Geo. H. Holland

Robert H.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C86992

C86992

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(Address).....

15-

JUL 26 1915

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed).....

7-26, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ROBERT KRAUTER

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 722 N. Stockton street, St. 16 WARD)

2-FULL NAME Harriet Ferguson,

(Residence in Baltimore: No. 722 N. Stockton street,

St.; yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed,

6-DATE OF BIRTH, Unknown, / (Month) (Day) (Year)

7-AGE, 55 yrs. 7 mos. 7 ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Cook, (b) General nature of industry, business, or establishment in which employed (or employer), Domestic.

9-BIRTHPLACE, (State or Country), Virginia,

10-NAME OF FATHER, William Welsh,

11-BIRTHPLACE OF FATHER (State or Country), Unknown,

12-MAIDEN NAME OF MOTHER Rachel Henderson,

13-BIRTHPLACE OF MOTHER (State or Country), Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Coleman, daughter,

(Address) 722 N. Stockton street.

15-

Filed JUL 26 1915 191. ROBERT KRAUTH

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24th, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute infective gangrene caused by accidentally stepping in a nail (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Campbell M. D. (Coroner.)

July 24 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Charlotteville Va 7/25/15

20-UNDERTAKER ADDRESS

Samuel R. Huxley 578 W. Biddle

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

C86994

HEALTH DEPARTMENT-CITY OF BALTIMORE

C86994

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 2020 E Pratt St. WARD 2)

2-FULL NAME Joe S. Hanighorst

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2020 E Pratt St. 38 yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6-DATE OF BIRTH December 18, 1877
(Month) (Day) (Year)

7-AGE 38 yrs. 7 mos. ds. or 39 mos. 7 ds. If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession, or particular kind of work Store General
(b) General nature of industry, business, or establishment in which employed (or employer) keeper

9-BIRTHPLACE (State or country) Baltimore Md.

10-NAME OF FATHER Denny Thirickford

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Mary Grossman

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Regina Schull
(Address) 2020 E Pratt St.

15. JUL 26 1915, ROBERT . KRAUTER,
Filed, 1915, Marital Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug 24, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1915 to Aug 24, 1915
that I saw him alive on Aug 24, 1915
and that death occurred, on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis

(Duration) 2 yrs. 2 mos. 2 ds.
Contributory (SECONDARY) Hemiplegia (Right)
(Duration) 1 yrs. 1 mos. 1 ds.

(Signed) Jeffries B. Buck M. D.
July 26, 1915 (Address) 2844 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 38 yrs. 7 mos. 7 ds. In the State 38 yrs. 7 mos. 7 ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Mary Redemptorist

20-UNDERTAKER Marcella Kypers

ADDRESS 37 S. Canal St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *175*)

FULL NAME

(Residence in Baltimore: No. *1703 Light St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St. *175*, yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Jan. 28, 1866
(Month) (Day) (Year)

7-AGE,

48 yrs. 5 mos. 26 da.

If LESS than 1 day,

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Grand Juror*
(b) General nature of industry, business, or establishment in which employed (or employer), *W. M. & R. Co.*

9-BIRTHPLACE, (State or Country),

Martinsburg W. Va.

10-NAME OF FATHER,

W. H. Cheeseman

11-BIRTHPLACE OF FATHER (State or Country),

W. Va.

12-MAIDEN NAME OF MOTHER

Lophia Shelton

13-BIRTHPLACE OF MOTHER (State or Country),

W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Queen Cheeseman*

(Address) *1703 Light St.*

15-

FILER

JUL 27 1915

HARRY O. ARDREY

191- *Barial Permit Clerk*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

And that said deceased came to death *on the day stated above.*

The CAUSE OF DEATH* was as follows:

Struck by United Railway Car Light on Bloomington (Accident) (Duration) *1* yrs. *1* mos. *1* da.

CONTRIBUTORY (Secondary) *Fractured Skull*

(Signed) *Edw. G. Smith* (Coroner.) *M. D.*

July 26, 1915. (Address) *517 Light St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs. *1* mos. *1* da. State *1* yrs. *1* mos. *1* da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery DATE OF BURIAL, *July 27, 1915*

20-UNDERTAKER

W. P. McLaughlin ADDRESS *1455 Light St.*

Every item of information inquires of exactly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2822 N. Harlem ave.* ST. *16* WARD)FULL NAME *Henry Baer*(Residence in Baltimore: No. *2822 N. Harlem ave* St. *16* yrs. *16* mos. *16* ds)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)6-DATE OF BIRTH, *Dec 7*, 1848
(Month) (Day) (Year)7-AGE, *66* yrs. *7* mos. *17* ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Shoe Maker*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *City*10-NAME OF FATHER, *Don't know*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *Elizabeth Hecker*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elizabeth Baer*(Address) *2822 N. Harlem ave*

15- JUL 27 1915. HARRY O. ANDERSON, Registrar.

Filed..... 1915. Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 24*, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 20*, 191*4*, to *July 24*, 191*5*, that I saw him alive on *July 24*, 1915, and that death occurred, on the date stated above, at *9:45 P.* m. The CAUSE OF DEATH* was as follows:*Leptothorax m. m. m.*
(Duration) ... yrs. *6* mos. ... ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) *Harry Boyd* M. D. *July 25*, 1915. (Address) *22 Columbia*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL; DATE OF BURIAL.

Western Cemetery *July 28*, 1915.

20-UNDERTAKER ADDRESS

*Geo. Weber & Son 2503 Elmwood**ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1610 Laureus* ST.; *16* WARD)2-FULL NAME *Charlotte Meyer*(Residence in Baltimore: No. *1610 Laureus* St.; — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *June 19, 1858*

(Month)

(Day)

(Year)

7-AGE, *57* yrs. *1* mos. *7* ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Charles B Meyer*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Anna Mary Morgenthau*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant), *Edward G. Clark*(Address), *207 N. Carrollton Ave*

15-

JUL 27 1915

HARRY O. ANDREWS,

Filed

191

Serial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 26th, 1915*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *July 7th* 1915 to *July 26th* 1915, that I saw her alive on *July 26th* 1915, and that death occurred, on the date stated above, at *1:40 p.m.*

The CAUSE OF DEATH* was as follows:

Gastric ulcer of Intestines
(Duration) ... yrs. *6* mos. ... ds.

CONTRIBUTORY (Secondary) *Metastasis to Liver*(Duration) ... yrs. *2* mos. ... ds.(Signed) *Edward G. Clark* M.D.*July 26, 1915* (Address) *207 N. Carrollton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Green Park*DATE OF BURIAL, *July 28, 1915*

20-UNDERTAKER

ADDRESS

Mr. White & Son 2503 Calmar Road
are

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *24* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Otto Naber(Residence in Baltimore: No. *631 E Fort Ave. City* St.; *20* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*White*5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Don't know, *1*.....
(Month) (Day) (Year)

7-AGE,

22

yrs. mos. ds.

If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Wireless Operator
Johns Hopkins Hospital
*Wireless Operator*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

Christopher Naber

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

*Annie Klover*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....*R. J. Heard*(Address).....*Johns Hopkins Hospital*

15-

*JUL 27 1915**HARRY O. ANDREWS,*Filed..... 191...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 26th, *1915*.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Mar 29th 1915, to *July 26th* 1915,
that I saw him alive on *July 26th* 1915,
and that death occurred, on the date stated above, at *8:20* m.

The CAUSE OF DEATH was as follows:

Tubercle Brain P.(Duration) *1* yrs. mos. ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. mos. ds.(Signed) *W. B. Davis*....., 191... (Address) *Johns Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *4* yrs. mos. ds. In the *20* yrs. mos. ds.Where was disease contracted, (if not at place of death?) *(?) 631 E Fort Ave*Former or usual residence *631 E Fort Ave*

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

*London Park**7/29*, 1915.

20-UNDERTAKER

ADDRESS

*William Cork**502 E North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

WARD

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word)

6-DATE OF BIRTH *July 4*, 1853
(Month) (Day) (Year)

7-AGE *62* - *21* yrs. - mos. - ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION *Housewife*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore*

10-NAME OF FATHER *Aug. L. M. Prossman*

11-BIRTHPLACE OF FATHER (State or country) *Ireland*

12-MAIDEN NAME OF MOTHER *Margaret M. Grew*

13-BIRTHPLACE OF MOTHER (State or country) *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William O. Pearce*

(Address) *1919 Wilkins Ave*

15. *JUL 27 1915* HARRY O. ANDREWS, Serial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 25*, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *7:18*, 1915, to *7:25* 1915, that I saw her alive on *7:24*, 1915, and that death occurred, on the date stated above, at *7:00* a. m. The CAUSE OF DEATH* was as follows:

Coronary Disease of Heart

Contributory (SECONDARY) *Unknown*

(Signed) *J. J. Cook* M. D.

7:26, 1915 (Address) *211 W. Lawrence*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR CREMATION *Linden Park Cem.* DATE OF BURIAL *July 27*, 1915

20-UNDERTAKER *J. J. Cook* ADDRESS *1003 N. Baltimore St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *1219 Ostend* ST.; *21* WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary Ellen Pilcher*(Residence in Baltimore: No. *1219 Ostend St.* St.; *51* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED, *widow*
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

March 27, 1838
(Month) (Day) (Year)

7-AGE,

77 yrs. *3* mos. *27* ds.

If LESS than 1 day.

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*none*9-BIRTHPLACE,
(State or Country),*Va*

10-NAME OF FATHER,

*Abraham W. Ford*11-BIRTHPLACE OF FATHER
(State or Country),*Va*

12-MAIDEN NAME OF MOTHER

*Elizabeth Piles*13-BIRTHPLACE OF MOTHER
(State or Country),*Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Burke*(Address) *1219 Ostend St.*15- *JUL 27 1915* HARRY O. ANDERSONFiled..... 191... *Marial Permit 0107* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 28, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 20, 1915, to July 24, 1915,*that I saw her alive on *July 24, 1915,*and that death occurred, on the date stated above, at *30* m.

The CAUSE OF DEATH* was as follows:

Paralysis of Heart

(Duration).... yrs.... mos.... ds.

CONTRIBUTORY *Heart prostration*
(Secondary)

(Duration).... yrs.... mos.... ds.

(Signed) *Shepherd Dray* M. D.101... (Address) *1227 Blenheim St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Olm's Cem. July 28, 1915

20-UNDERTAKER

ADDRESS

John S. Cook 103 N. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw h alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH *3606 Danison Ave*

REGISTERED NO. C. *120*

CITY OF BALTIMORE: (No. *3606 Danison Ave* ST. *15* WARD)

2-FULL NAME *Samuel A. Burman*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1108 Laurens* St.; *40* yrs. *11* mos. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *Married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Aug 26*, 18*49*
(Month) (Day) (Year)

7-AGE *65* yrs. *11* mos. *15* ds. or min.?
If LESS than 1 day, hrs., min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *Housekeeper*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *MD.*

10-NAME OF FATHER *St. Petmate*

11-BIRTHPLACE OF FATHER (State or country) *Germany*

12-MAIDEN NAME OF MOTHER *Louisa Schwiskey*

13-BIRTHPLACE OF MOTHER (State or country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. H. Burman*

(Address) *1108 Laurens St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July*, 191*5*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Oct 6*, 191*4*, to *July 25*, 191*5*,
that I saw him alive on *July 25*, 191*5*,
and that death occurred, on the date stated above, at *11* m.

The CAUSE OF DEATH* was as follows:
Neurostric, Intestinal

Contributory (SECONDARY) *Arterio Sclerosis*
(Duration) *7* yrs. *11* mos. *15* ds.

(Signed) *Dr. H. F. Fetter* M. D.
July 27, 191*5*. [Address] *2072 E. Howard St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *1108 Laurens St.* yrs. *11* mos. *15* ds. State *MD.*

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *St. Paul's Lutheran Church* DATE OF BURIAL *July 28*, 191*5*

20-UNDERTAKER *Mrs. G. White* ADDRESS *730 Pine Ave*

15 JUL 27 1915

HARRY O. ANDREWS,
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87004

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *6* WARD)2-FULL NAME *Goldie Gadden*(Residence in Baltimore: No. *1512 Mulligan St. Baltimore* St.; yrs. mos. *14* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

July 10th, 1915.
(Month) (Day) (Year)

7-AGE,

yrs. mos. *14* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Stephen Gadden*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Blanche Chase*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Rosel*(Address) *Johns Hopkins Hospital*

15-

JUL 27 1915

191.

JOHNS HOPKINS HOSPITAL

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 25th, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 24th* 1914, to *July 25th* 1915, that I saw him alive on *July 25th* 1915, and that death occurred, on the date stated above, at *9:45 a.m.*

The CAUSE OF DEATH* was as follows:

Congenital syphilis(Duration) yrs. mos. *14* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *A. S. Roth* M. D.*July 26th*, 1915. (Address) *Johns Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *14* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1512 Mulligan St. Balt. Md.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

JOHNS HOPKINS HOSPITAL JUL 27 1915

20-UNDERTAKER

ADDRESS

Commissioner Health.

FOR ANATOMICAL PURPOSES.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-JUL 27 1915

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

July 8th 1915, to July 24th 1915,

that I saw her alive on July 23rd 1915,

and that death occurred, on the date stated above, at 4.15 m.

The CAUSE OF DEATH* was as follows:

Mention

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) J. E. Sullivan M. D.

July 24th 1915 (Address) 615 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

COLLEGE OF P. & S. DATE OF BURIAL

JUL 28 1915

20-UNDERTAKER

Commissioner Health.

ADDRESS

FOR ANATOMICAL PURPOSES.

THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

887006

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

887005

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *637 W. North Ave.* ST. *14* WARD)

2 FULL NAME

Anna S. Ramsey

(Residence in Baltimore: No.

637 W. North Ave.

St. *64* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow*
(Write the word)

6 DATE OF BIRTH *Unknown*, 1
(Month) (Day) (Year)

7 AGE *64* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work *House work.*
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Balto. Md.*

10 NAME OF FATHER *Dr. Edward P. Trous.*

11 BIRTHPLACE OF FATHER (State or country) *Balto. Md.*

12 MAIDEN NAME OF MOTHER *Rebecca Sewell*

13 BIRTHPLACE OF MOTHER (State or country) *Balto. - Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Anna P. Harrison*

(Address) *647 W. North Ave.*

15 JUL 27 1915 HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July-26, 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *1910* to *July 26, 1915*, that I saw her alive on *July 26, 1915*, and that death occurred, on the date stated above, at *10:30 P.M.*
The CAUSE OF DEATH* was as follows:

Myocarditis

Contributory (Duration) *4 yrs. + mos. ds.*
Pulmonary Edema - Asthma
(Signed) *Wilbur P. Stubbins* M. D.
July 26, 1915 (Address) *647 W. Calhoun St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Mt. Olivet* DATE OF BURIAL *July 28, 1915*

20 UNDERTAKER *Geo W Little* ADDRESS *531 N. Fremont Ave.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *607 E. Glen St.* ST. *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Lucenia Clemons*(Residence in Baltimore: No. *607 E. Glen St.* St. *25* yrs., *—* mos., *—* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *May 15, 1865*

(Month)

(Day)

(Year)

7-AGE, *51* yrs., *2* mos., *10* da.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer) *Housework*9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Don't know*11-BIRTHPLACE OF FATHER (State or Country), *Don't know*12-MAIDEN NAME OF MOTHER *Don't know*13-BIRTHPLACE OF MOTHER (State or Country), *Don't know*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rachel Clemons*(Address) *607 E. Glen St.*

15-

JUL 27 1915

EAST O. ADAMS,

1915 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 25, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 1, 1915*, to *July 25, 1915*, that I saw him alive on *July 23, 1915*, and that death occurred, on the date stated above, at *3:45* m.

The CAUSE OF DEATH* was as follows:

*Old age -
Acute Bronchitis
Cardiac dilatation*(Duration) *7* yrs., *2* mos., *—* da.

CONTRIBUTORY (Secondary)

(Duration) *7* yrs., *2* mos., *—* da.(Signed) *M. B. Stueben, M. D.**July 26, 1915* (Address) *682 E. Glen St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs., *—* mos., *—* da. In the State *—* yrs., *—* mos., *—* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt Auburn Ctry*DATE OF BURIAL, *July 27, 1915*20-UNDERTAKER *Alfred J. Ireland*ADDRESS *1445 Camden St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Mercy Hosp* ST. *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *George Winkler*(Residence in Baltimore: No. *1229* St. *5* yrs. *1* mo. *1* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *July 7, 1862*7-AGE, *52* yrs. *5* mos. *18* da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Sabon Day*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Germany*

PARENTS.

10-NAME OF FATHER, *Gotlob Winkler*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Dora Winkler*(Address) *1710 N. 1st St.*

15-

JUL 27 1915 HARRY O. ANDREWS,
FILED 1915 Social Permit Office
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 25, 1915*

(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *July 20, 1915*, to *July 25, 1915*, that I saw him alive on *July 25, 1915*, and that death occurred, on the date stated above, at *8* p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
operation 3 days previous
death
(Duration) *Do not know* yrs. *1* mo. *1* da.CONTRIBUTORY (Secondary) *Haematemesis*(Duration) *Do not know* yrs. *1* mo. *1* da.
(Signed) *Frank W. Rogers* M. D.*July 25, 1915*, (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *6* da. In the *5* yrs. mos. da. StateWhere was disease contracted, if not at place of death? *Do not know*Former or usual residence *1229 Louis St.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL, *July 28, 1915*20-UNDERTAKER *John S. Jones*ADDRESS *John S. Jones*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

alt 30 St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

Unknown, 1867

7-AGE,

48

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer)

Day Laborer

9-BIRTHPLACE, (State or Country),

Md

10-NAME OF FATHER,

Brown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edward Brown

(Address)

9 N. Vincent Alley

15-

ROBERT KRAUTER,

Regist. JUL 27 1915, Burial Permit Office

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 26th 1915

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry

thereon and from the evidence obtained by said

inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed) Saml. M. D.

July 25th 1915 (Address) 230 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs., mos., ds. State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Int. Auburn July 28, 1915

20-UNDERTAKER

ADDRESS

James H. Denny 1303 Reservoir

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87010 HEALTH DEPARTMENT—CITY OF BALTIMORE
104
87010

CERTIFICATE OF DEATH

1 PLACE OF DEATH n.
CITY OF BALTIMORE: (No. 1320 Vincent St. 15 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Minnie Hiles
(Residence in Baltimore: No. 1320 Vincent St. yrs. mos. 21 da.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE MARRIED Widowed OR DIVORCED (Write the word) Chua
6 DATE OF BIRTH Unknown (Month) (Day) 1 (Year)
7 AGE 7 yrs. mos. ds. or min. 1 day, hrs. min.?
8 OCCUPATION (a) Trade, profession or particular kind of work Chua (b) General nature of industry, business, or establishment in which employed (or employer)
9 BIRTHPLACE (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Chua Hiles
11 BIRTHPLACE OF FATHER (State or country) Annapolis Md
12 MAIDEN NAME OF MOTHER Eliza Brown
13 BIRTHPLACE OF MOTHER (State or country) Annapolis Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Brown
(Address) 1324 Centre St

15- JUL 27 1915. HONERT. KRAUTER. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 26, 1915 (Month) (Day) (Year)
17 I HEREBY CERTIFY, That I attended deceased from July 23, 1915, to July 26, 1915, that I saw her alive on July 23, 1915, and that death occurred, on the date stated above, at 9:10 P.M. The CAUSE OF DEATH* was as follows:
Gastro-Enteritis
(Duration) yrs. mos. 1 ds.
Contributory (SECONDARY)
(Signed) W. P. Bailey M. D.
7/27, 1915. [Address] 9534 Mont St.
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18 LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death yrs. mos. ds. in the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence
19 PLACE OF BURIAL OR REMOVAL Mt Zion 20 UNDERTAKER James T. Davis
DATE OF BURIAL July 28, 1915
ADDRESS 1303 Eastman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1759 E. Preston* ST. *8* WARD)

2-FULL NAME *August W. Schmidt*

(Residence in Baltimore: No. *1759 E. Preston* St. *37* yrs. *5* mos. *11* ds.)

REGISTERED No. C. *45*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

February

14th

1878

(Month)

(Day)

(Year)

7-AGE

37

yrs.

5

mos.

11

ds.

or

min.?

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Retail Druggist

9-BIRTHPLACE

(State or country)

Baltimore, Ind.

10-NAME OF FATHER

Wm. H. Schmidt

11-BIRTHPLACE OF FATHER

(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Wm. / Kamm

13-BIRTHPLACE OF MOTHER

(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry F. Lindeman

(Address)

1100 S. Charles St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July

25

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov. 14, 1914, to July 25, 1915,

that I saw him alive on *July 25, 1915,*

and that death occurred, on the date stated above, at *11.30 a.m.*

The CAUSE OF DEATH* was as follows:

Sarcoma of neck
(Operation performed and Specimen of Tumor examined)

(Duration) *2* yrs.

mos.

ds.

Contributory (SECONDARY)

(Duration) *2* yrs.

mos.

ds.

(Signed) *Robert J. Green* M. D.

July 26, 1915 [Address] *120 1/2 Aisquith*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place

of death

..... yrs. mos. ds.

In the

State

..... yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cem.

July 28, 1915

20-UNDERTAKER

ADDRESS

E. Schuman & Son

1039

ROBERT J. KRAUTER
Bureau Permit Clerk
REGISTRAR

Filed *7/27/15* 1915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3129 Dillon St. ST.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicholas N. Glass

(Residence in Baltimore: No. 3129 Dillon St. St.; 1 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, October 28, 1912. (Month) (Day) (Year)

7-AGE, 2 yrs., 8 mos., 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, Geo. W. Glass

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Elizabeth C. Smith

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....Geo. W. Glass.....

(Address)....3129 Dillon St.

15-

JUL 27 1915

ROBERT . KRAUTER, Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 24, 1915, to July 25, 1915, that I saw him alive on July 25, 1915, and that death occurred, on the date stated above, at 3:47 m. The CAUSE OF DEATH* was as follows:

Cardiac Paralysis (Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Acute Meningitis

(Signed)..... (Duration)....yrs....mos....ds.

(Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Abingdon Md. DATE OF BURIAL, July 28, 1915

20-UNDERTAKER ADDRESS

Wm. C. Black, 927 N. Broadway,

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 S. Ellwood Ave. ST.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Babetta E. Rau(Residence in Baltimore: No. 3112 E. Baltimore St. St.; 40 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, March 3, 1859
(Month) (Day) (Year)

7-AGE, 56 yrs., 4 mos., 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER, John Pittroff

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Harry Ritterpusch(Address) 21 S. Ellwood Ave.

15-

JUL 27 1915 ROBERT KRAUTER,
FILL Registral Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12 1915, to July 27 1915, that I saw h alive on July 26 1915, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pylorus
(Operation + removal of same)

(Duration) 6 yrs., mos., ds.
CONTRIBUTORY (Secondary) Alcoholism

(Signed) Chas. F. Black M. D.
July 27, 1915 (Address) 253 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn Cem.

DATE OF BURIAL,

July 30, 1915

20-UNDERTAKER

Wm. C. Black, 927 N. Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2287 N. Gilman* ST. *19* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2287 N. Gilman* St.; *67* yrs., *1* mos., *23* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

June 2, 1848
(Month) (Day) (Year)

7-AGE,

67 yrs., *1* mos., *23* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE, (State or Country),

Balto.

PARENTS.

10-NAME OF FATHER,

Patrick Callahan

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary Cullen

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Callahan*(Address) *2287 N. Gilman St.*

15- JUL 27 1915

ROBERT KRAUTER

Filed..... 191

Marial Formik Oler

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 25, 191*5*
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 20* 191*5*, to *July 25* 191*5*, that I saw her alive on *July 25* 191*5*, and that death occurred, on the date stated above, at *9 P.* m.
The CAUSE OF DEATH* was as follows:*Calculus of the*
(Duration)..... yrs..... mos..... ds. *5*

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.
(Signed) *E. H. Howard* M. D.
9/26, 191*5*. (Address) *838 E. Pratt St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral Cem**7/28*, 191*5*

20-UNDERTAKER

ADDRESS

Chas. H. Evans & Son 118 W. Mt. Royal

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE LEGIBLY, WITH CHANGING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2223 E North Ave* ST. *8* WARD) *79*

2-FULL NAME

William Eberenz Sr.

(Residence in Baltimore: No. *2223 E North Ave* St. *56* yrs., *7* mos., *3* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE

Married
(Write the word.)

6-DATE OF BIRTH,

Dec 23rd, 1888
(Month) (Day) (Year)

7-AGE,

56 yrs., *7* mos., *3* ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Retired
Brassery Worker

9-BIRTHPLACE, (State or Country).

Balto. Md.

10-NAME OF FATHER,

Simon Eberenz

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Margaret Schilling

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Clara Schmidt*

(Address) *2223 E North Ave*

15-

FILED

JUL 27 1915

ROBERT KRAUTER,

Surgeon General

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 26, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*
(Inquest, autopsy or inquiry.)

and that said deceased came to death *on the day stated above.*

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) *sudden* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Elyah J. Russell* M. D.
(Coroner.)

July 26, 1915 (Address) *423 N Broadway*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Loudon Park Cem

July 29th 15

20-UNDERTAKER

ADDRESS

George Schilling & Son 1126 E Monument

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

087016

HEALTH DEPARTMENT—CITY OF BALTIMORE

087016

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1321 Bayard*)

ST. *21* WARD

REGISTERED NO. C

2-FULL NAME

Louise Clark

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1321 Bayard St.*)

St. *21* yrs. *1* mos. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH

November

1877

(Month) (Day) (Year)

7-AGE

38

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer). *General*

9-BIRTHPLACE,

(State or Country).

Md. (Balt City)

10-NAME OF FATHER,

Sam Smith

11-BIRTHPLACE

OF FATHER (State or Country).

Md.

12-MAIDEN NAME OF MOTHER

Nancy Troy

13-BIRTHPLACE

OF MOTHER (State or Country).

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Smith

(Address)

1321 Bayard

15-

JUL 28 1915

HARRY O. ANDREWS,

Filed *191* Serial *Permit* *Clark*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

24th, *1915*

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

toxy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) *7* yrs. *1* mos. *15* ds.

CONTRIBUTORY (Secondary)

(Duration) *7* yrs. *1* mos. *15* ds.

(Signed)

Wm. H. Savage M. D.

(Coroner.)

July 26, 1915 (Address) *1729 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *7* yrs. *1* mos. *15* ds. In the State *7* yrs. *1* mos. *15* ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Int Auburn Cemetery

July 28, 1915

20-UNDERTAKER

ADDRESS

Geo H Hooper

609 Little Rock

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE FULLY, WITH CAREFULNESS FOR THIS IS A PERMANENT RECORD

C87017

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Mary Hospital* ST. *5* WARD)

2-FULL NAME

Heodor Marchio (= Magini)

(Residence in Baltimore: No. *411 N. Front St*

St. *5* yrs., *1* mos. — *175* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-STATUS.

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

1 (Month) *1* (Day) *1* (Year)

7-AGE,

35

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Tailor
clock face

9-BIRTHPLACE.

(State or Country),

Italy

10-NAME OF FATHER,

2

11-BIRTHPLACE OF FATHER

(State or Country),

7

12-MAIDEN NAME OF MOTHER

7

13-BIRTHPLACE OF MOTHER

(State or Country),

7

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Police Records*

(Address).....

15-

FIND

JUL 28 1915

HARRY O. ANDREWS,

191. Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

26, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry)

Inquest and that said deceased came to *death* (Cause of death) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident - Fell off electric car (United B. & O. Co.)
Sub. dural hemorrhage.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Thos. R. Chamber* M. D.
(Coroner.)

July 22 1915 (Address) *18 N. Front St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

St. Vincent's Cem.

DATE OF BURIAL,

July 28, 1915

20-UNDERTAKER

Lilly & Co. Baltimore

ADDRESS

4038 W. 1st St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 Beward ST.; 11 WARD)

REGISTERED No. C

2-FULL NAME Lavinia Brown(Residence in Baltimore: No. 1202 Beward St.; 30 yrs., — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE Colored5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH July 1864

(Month)

(Day)

(Year)

7-AGE 57

yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Private9-BIRTHPLACE,
(State or Country) W. Va.10-NAME OF FATHER, John Stephens11-BIRTHPLACE OF FATHER
(State or Country) W. Va.12-MAIDEN NAME OF MOTHER Sarah Rose13-BIRTHPLACE OF MOTHER
(State or Country) W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Brown(Address) 1202 Beward St.

15-

JUL 28 1915

HARRY O. ANDREWS,

Filed....., 191

Burial Permit Order

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July 1/26, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1st 1915, to July 26th 1915, that I saw him alive on July 26th 1915, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Acute Hepatitis(Duration) 6 yrs. 6 mos. 10 ds.CONTRIBUTORY (Secondary) Self Neglect(Duration) 7 yrs. 1 mos. 10 ds.(Signed) A. L. Ellis, M. D.7/28, 1915. (Address) 724 N. W. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. 1 mos. 10 ds. In the State 7 yrs. 1 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. BeebeDATE OF BURIAL July 28 191520-UNDERTAKER Edmund ThomasADDRESS 58 N. W. St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1853 Karanauy* ST.; *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Ernest James Farrell*Residence in Baltimore: No. *1853 Karanauy*St.; yrs. *10* mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Sept. 24, 1914
(Month) (Day) (Year)

7-AGE,

10 mos. 2 ds.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Md. (Baltimore)

10-NAME OF FATHER,

Richard D. Farrell

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Helen R. Gittings

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Helen R. Farrell*(Address) *1853 Karanauy St.*

15-

JUL 28 1915

HARRY C. ANDREWS,

Filed....., 191..

Serial Permit: *Clary*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 27, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 26, 1915 to *July 26, 1915*that I saw him alive on *July 26, 1915* and that death occurred, on the date stated above, at *2:30* p.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis(Duration)..... yrs..... mos. *3* ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *John D. Quinn M. D.**July 27, 1915.* (Address) *1507 N. Fulton Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*St. Peter's**July 28, 1915*

20-UNDERTAKER

ADDRESS

Carroll & Sons 1364 N. E. Ave

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE, (No. *1037 N Dallas*)

ST.:

WARD) *7*

REGISTERED NO. C

2-FULL NAME

Charles H. Diehl

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1037 N Dallas*)St.; *61* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

*Sept**6**1837*

(Month)

(Day)

(Year)

7-AGE,

*77**10* yrs., *21* mos., *21* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired Tailor

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER (State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Magdalena Diehl*(Address) *1037 N Dallas*

15-

JUL 28 1915

HARRY O. ANDERSON,

Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**27*, 191*5*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 16* 191*5*, to *July 27* 191*5*, that I saw him alive on *July 26* 191*5*, and that death occurred, on the date stated above, at *2:20* p.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis(Duration) *6* yrs., *6* mos., *4* ds.

CONTRIBUTORY (Secondary)

(Duration) *4* yrs., *4* mos., *4* ds.(Signed) *A. L. Tumbleson* M. D.*July 27* 191*5* (Address) *2013 Banks*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Baltimore County

DATE OF BURIAL,

July 29, 191*5*

20-UNDERTAKER

Henry Storer, Sen

ADDRESS

1301 E Saginaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Lucy Hopkins(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs. *2* mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

April
(Month)*15*
(Day)*1915*
(Year)

7-AGE,

yrs. *3* mos. *11* ds.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*15-
JUL 28 1915

HARRY O. ANDREWS,

Filed.....

101

Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July
(Month)*26*
(Day)*1915*
(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1st 1915, to *July 25* 1915,that I saw her alive on *July 25* 1915,and that death occurred, on the date stated above, at *4:45* p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) yrs. *2* mos. *2* ds.

CONTRIBUTORY

(Secondary) *M. abruption*(Duration) yrs. *2* mos. *2* ds.(Signed) *J. P. Sullivan*

M. D.

July 26, 1915. (Address) *615 Columbia Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. *6* ds. In the State yrs. *3* mos. *11* ds.Where was disease contracted, if not at place of death? *St. Vincent's Infant Asylum*Former or usual residence *St. Vincent's Infant Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral Cemetery**July 28*, 1915

20-UNDERTAKER

ADDRESS

*Martin Fahy**606 Lafayette Ave.*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infirmary*)ST.: *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Joseph J. Anthony(Residence in Baltimore: No. *St. Vincent's Infant Asylum*)St.: yrs., *1* mo., *12* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) *Single*

6-DATE OF BIRTH,

*About**January**1915*

7-AGE,

6 yrs., *6* mo., *12* da.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

Filed

*JUL 28 1915**BARRY O. ANDERSON**191... Mortal Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 25, 1915

17- I HEREBY CERTIFY, That I attended deceased from

*July 13, 1915, to July 25, 1915*that I saw him alive on *July 25, 1915*and that death occurred, on the date stated above, at *2:30 P.M.*

The CAUSE OF DEATH* was as follows:

Dysentery(Duration) yrs. mo. *12* da.CONTRIBUTORY
(Secondary)

(Duration) yrs. mo. da.

(Signed) *J. J. Sullivan* M. D.*July 26, 1915* (Address) *615 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mo. *12* da. In the State yrs. *6* mo. da.

Where was disease contracted, if not at place of death?

Former or usual residence *St. Vincent's Infant Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cem July 28 1915

20-UNDERTAKER

ADDRESS

Marlin L. Lohr Sons 606 Lafayette Ave

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

C87023

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf't Asy.*)ST.: *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Clotildis Bailey(Residence in Baltimore: No. *St. Vincent's Infant Asylum*)St.: yrs., *1* mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) *Single*

6-DATE OF BIRTH

May 26, 1915
(Month) (Day) (Year)

7-AGE

1 mos. 29 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE

(State or Country),

Maryland

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

JUL 28 1915

Filed

101

HARRY O. ANDREWS,

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 25, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1st* 1915, to *July 25* 1915, that I saw her alive on *July 25* 1915, and that death occurred, on the date stated above, at *12:30 P.m.*

The CAUSE OF DEATH* was as follows:

*M. abnutrition &**M. al. assimilation*(Duration) yrs. *1* mos. *29* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. *1* mos. *29* ds.(Signed) *J. E. Boulton* M. D.*July 26, 1915* (Address) *615 Columbia Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *14* ds. In the State yrs. *1* mos. *29* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

St. Vincent's Infant Asylum

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cathedral Cemetery**July 28, 1915*

20-UNDERTAKER

ADDRESS

*Martin F. Hayes & Sons**101 Lafayette Ave*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (NO

ST.

WARD

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUL 28 1915

HARRY O. ANDREWS,

191. Serial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry O. Andrews, M. D.

(Coroner) July 28 1915 (Address) 1026 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1114 Newman* ST.: *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *J. J. McDermott*(Residence in Baltimore: No. *1114 Newman Court* St.: yrs., *3* mon. *23* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

*April**3**P.M.*

(Month)

(Day)

(Year)

7-AGE,

*3**23*

ds.

If LESS than 1 day,

hrs. or mins.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),*Balt Md.*

10-NAME OF FATHER,

Patrick McDermott

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Bridgett Parsons

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Patrick McDermott*(Address) *1114 Newman St*

15-JUL 28 1915

HARRY O. ANDREWS,

Filed..... 1915.. *Marial Parmlt. Qlar*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

(Month)

(Day)

26, 191*5* (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 20 191*5*, to *July 26* 191*5*,that I saw him live on *July 26* 191*5*,and that death occurred, on the date stated above, at *10:30* p.m.

The CAUSE OF DEATH* was as follows:

*Asphyxia
Malnutrition*(Duration) yrs. mos. *10* ds.CONTRIBUTORY
(Secondary)(Duration) yrs. mos. *10* ds.(Signed) *F. H. Barry* M. D.*7-25*, 191*5* (Address) *774 Carey*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Peter's Cemetery *July 28*, 191*5*

20-UNDER TAKER

ADDRESS

John F. Field *1200 N. Lombard St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87026

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *1218 Columbia Ave* ST. *21* WARD)

FULL NAME *Jacob C. Essemwanger*

(Residence in Baltimore: No. *1218 Columbia Ave* Sr. *—* yrs. *—* mos. *—* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Aug. 1st, 1843
(Month) (Day) (Year)

7 AGE

71 yrs. *11* mos. *27* ds. If LESS than 1 day, — hrs. or — min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

Germany

10 NAME OF FATHER

Jacob Essemwanger

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Johnson

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Essemwanger

(Address)

1218 Columbia Ave

JUL 28 1915

HARRY O. ANDREWS,

Marial Permit Clerk.

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 27, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 7, 1915 to July 27, 1915

that I saw him alive on *July 26, 1915*

and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Clinical Diagnosis) (Duration) *1* yrs. *20* mos. *20* ds.

Contributory (SECONDARY)

(Duration) *1* yrs. *20* mos. *20* ds.

(Signed) *Edward H. London, M. D.*

July 27, 1915 (Address) *750 W. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery

July 30th, 1915

20 UNDERTAKER

ADDRESS

Johns Field 1200 N. Howard St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2646 Guilford ave.* St.; *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Katherine Watkins*(Residence in Baltimore: No. *2646 Guilford ave* St.; *11* yrs., *11* mos., *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*4-COLOR OR RACE. *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)6-DATE OF BIRTH, *Aug 16, 1914*

(Month)

(Day)

(Year)

7-AGE, *11* yrs., *11* mos., *11* ds.IF LESS than 1 day, *hrs.* or *min.*

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, *Balto*
(State or Country),

PARENTS.

10-NAME OF FATHER, *Wilmer C. Watkins*11-BIRTHPLACE OF FATHER, *Balto*
(State or Country),12-MAIDEN NAME OF MOTHER, *May Emerson*13-BIRTHPLACE OF MOTHER, *Md*
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wilmer C. Watkins*(Address) *2646 Guilford ave*

15-

JUL 28 1915

Filed

191

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 27th 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 26, 1915* to *July 27, 1915*, that I saw her alive on *July 27, 1915*, and that death occurred, on the date stated above, at *4:30 p. m.*

The CAUSE OF DEATH* was as follows:

Cerebro-spinal meningitis(Duration) *1* yrs., *1* mos., *1* ds.CONTRIBUTORY (Secondary) *Whooping Cough & Broncho-pneumonia*(Duration) *10* yrs., *10* mos., *10* ds.(Signed) *J. F. Hall*7-28, 1915 (Address) *18 R. M. Hall*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *11* yrs., *11* mos., *11* ds. In the State *11* yrs., *11* mos., *11* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Druid Ridge*DATE OF BURIAL, *July 28, 1915*20-UNDERTAKER, *F. A. Krane*ADDRESS, *703 Hanover*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *417 D. Bond*)

ST:

WARD)

2-FULL NAME

Magmierz Fursiak

(Residence in Baltimore: No. *417 D. Bond St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St: *11* yrs. *5* mos. *19* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Feb *8*, *1915*
(Month) (Day) (Year)

7-AGE,

5 yrs. *5* mos. *19* ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Thomas Fursiak

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Frances Pawlowska

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Francis Fursiak*

(Address) *417 D. Bond St.*

15-*JUL 28 1915*

Filed *1915* *Barry O. Anderson* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 27, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cutters Colitis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *D. W. Jones* M. D.

July 28, *1915* (Address) *316 Odumville St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL, *July 28*, *1915*

20-UNDERTAKEN

William Fickowski

ADDRESS,

1618 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

C87029

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87029

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

104
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(If read the word)

6 DATE OF BIRTH

7 AGE

If LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

Contributory
(SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JUL 28 1915

Filed

JUL 28 1915

HARRY O. ANDREWS

Marial Permit Clerk

Union Bridge Md

July 28, 1915

Mrs J. E. Evans

1428

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *411 S. Durham* ST.: *V* WARD)

FULL NAME *James H. Ross.*

(Residence in Baltimore: No. *411 S. Durham*

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., *30* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)

6-DATE OF BIRTH, *Jan 10th*, *1848* (Month) (Day) (Year)

7-AGE, *67* yrs., *6* mos., *16* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Retired* (b) General nature of industry, business, or establishment in which employed (or employer), *Laborer, General*

9-BIRTHPLACE, (State or Country), *Norfolk Va.*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *W. S.*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *W. S.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Florence Ross*

(Address) *411 S. Durham St.*

15- *JUL 28 1915* *BARRY O. ANDREWS* *Clark* Filed *191* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 26th*, *1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

topsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *D. W. Jones* M. D. (Coroner.)

July 26th 1915. (Address) *3116 Osbourne St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death.... yrs. mos. ds. State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Oak Lawn* DATE OF BURIAL, *July 28th*, 1915

20-UNDERTAKER, *Lilly & Jones* ADDRESS, *403 S. Wolfe St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 S Central ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 420 S Central ave St. 3 yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

January 14, 1873
(Month) (Day) (Year)

7-AGE,

42 yrs. 6 mos. 13 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House Keeper

9-BIRTHPLACE,

(State or Country),

Ireland

10-NAME OF FATHER,

James Hoben

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Brigit Rochford

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Hoben(Address) 420 S Central ave

15-

JUL 28 1915Filed 1915 NOTARIAL PUBLIC CLARK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 27, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 1, 1915, to July 27, 1915,that I saw her alive on July 27, 1915,and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

acute Phthisis(Duration) 2 yrs. 7 mos. 27 ds.

CONTRIBUTORY

(Secondary)

(Duration) 15 yrs. 15 mos. 15 ds.(Signed) J. M. Clark M. D.July 27, 1915 (Address) 16 S Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St Vincent

DATE OF BURIAL,

July 28, 1915

20-UNDERTAKER

Wendell Dwyer & Son 37 S Mon

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2229 E. Baltimore* ST.: *1* WARD)

2-FULL NAME

Fred Caruthers(Residence in Baltimore: No. *2229 E. Baltimore* St.: *unknown* yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

*Feb**2**1915*

(Month)

(Day)

(Year)

7-AGE,

*45**5**25*

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Medical Doctor*

9-BIRTHPLACE, (State or Country),

Tenn.

PARENTS.

10-NAME OF FATHER,

John A. Caruthers Mr.

11-BIRTHPLACE OF FATHER (State or Country)

Tenn.

12-MAIDEN NAME OF MOTHER

Minnie Belle

13-BIRTHPLACE OF MOTHER (State or Country),

Tenn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Leila Holittle

(Address)

2229 E. Baltimore St.

15-

JUL 28 1915**ROBERT . KRAUTER,**

Filed

191. **Burial Permit Clerk**
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**27**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 13, 1915**to July 27**1915*

that I saw him alive on

*July 27**1915*

and that death occurred, on the date stated above, at

535 P.M.

The CAUSE OF DEATH was as follows:

Enterocolitis (cause unknown)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Carcinoma (?) (Germine)

(Duration) yrs. mos. ds.

Intestines (pancreas)(Signed) *Pearce Kunking*

M. D.

July 27, 1915 (Address) *1321 S. Charles St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

David Ridge Cemetery

DATE OF BURIAL,

July 30, 1915

20-UNDERTAKER

J. E. Hughes

ADDRESS

17 S. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 Argyll Ave. St. 17 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1313 Argyll Ave. St.; Life Time yrs. 1 mos. 1 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Col5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH.

Dec 19, 1900
(Month) (Day) (Year)

7-AGE.

14 yrs. 4 mos. 8 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. School boy
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Balto

10-NAME OF FATHER.

Hollis Briscoe

11-BIRTHPLACE OF FATHER (State or Country),

MD

12-MAIDEN NAME OF MOTHER

Hattie Carroll

13-BIRTHPLACE OF MOTHER (State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Chase(Address) 1400 Mosher

15-

JUL 28 1915HONNERT . KRAUTERFiled Bar. 12 Permit G. 12 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 28, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 27, 1915, to July 28, 1915that I saw him alive on July 27, 1915and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Gastro Enteritis
(D.B. Intestinal)(Duration) 7 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) 7 yrs. 1 mos. 1 ds.(Signed) M. D.July 28, 1915. (Address) 6 P. J. W. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. 1 mos. 1 ds. In the State 7 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

St. Anthony

DATE OF BURIAL.

July 30, 1915

20-UNDERTAKER

Sam. H. Chase

ADDRESS

1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1800 E Fayette* ST.; *6* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Hinda Labovitz*(Residence in Baltimore: No. *1800 E Fayette* St.; *14* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*6-DATE OF BIRTH, *Unknown*

(Month)

(Day)

(Year)

7-AGE, *53* yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Russia*10-NAME OF FATHER, *Abraham Smelnick*11-BIRTHPLACE OF FATHER (State or Country), *Russia*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry Labovitz*(Address) *1800 E Fayette St.*

15-

JUL 28 1915

Filed

ROBERT J. KRAUTH
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 28*, 191*5*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *in or before* 191*2*, to *July 18 (7) 1915*, that I saw h^e alive on *July 18 (about) 1915*, and that death occurred, on the date stated above, at *4 P. m.*

The CAUSE OF DEATH* was as follows:

*Pulmonary tuberculosis
(with cavity formation)*(Duration) *3* yrs. mos. ds.CONTRIBUTORY (Secondary) *Chronic nephritis*(Duration) *1* yr. mos. ds.(Signed) *Dr. Frank D. Smith* M. D.*July 28, 1915* (Address) *1126 Calver Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1800 E Fayette St.*19-PLACE OF BURIAL OR REMOVAL, *Hebrew Burial Pl. Co.*DATE OF BURIAL, *July 29, 1915*20-UNDERTAKER *S. L. Linton & Co. Balto St.*ADDRESS *1107 E*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 53 yrs., 2 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED, Widowed,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

May 2nd, 1862
(Month) (Day) (Year)

7-AGE.

53 yrs., 2 mos., 25 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.(b) General nature of industry, business,
or establishment in which
employed (or employer).

none

9-BIRTHPLACE,
(State or Country).

Baltimore Md

10-NAME OF
FATHER.

Richard Jones

11-BIRTHPLACE
OF FATHER
(State or Country).

England

12-MAIDEN NAME
OF MOTHER

Mary A Walker

13-BIRTHPLACE
OF MOTHER
(State or Country).

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Miles

(Address) 303 N. Guilford ave

15-

JUL 28 1915

ROBERT KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 27, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from
June 1914 to July 26 1915,
that I saw her alive on July 26 1915,
and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach
(Clinical Diagnosis & X-Ray)

(Duration) 1 yrs., 2 mos., 25 ds.

CONTRIBUTORY
(Secondary)

(Duration) 2 yrs., 2 mos., 25 ds.

(Signed) Stanley Miles M. D.

7/28, 1915. (Address) 1609 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.

Baltimore Cemetery

DATE OF BURIAL.

July 28, 1915.

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 817 S. Paca St. 21

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Racinkuti

(Residence in Baltimore: No. 817 S. Paca St.

St.: — yrs. — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

JUL 29 1915

HARRY O. ANDREWS,

Filed 191. Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on July 28 1915, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis
malnutrition
(Duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)

(Signed) M. C. Trilinger M. D.
July 28 1915 (Address) 682 Columbia St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, State (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer

July 29 1915

20-UNDERTAKER

ADDRESS

John Greblanek 500 S. Paca St.

N. B.—Every item of information should be carefully supplied. NO. 2, Bureau of Vital Statistics. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

BALTIMORE MD
637 Church St. 22

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

Infant Wilson
637 Church St.

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

July 26

(Month)

(Day)

1915
(Year)

7-AGE,

40 hr

If LESS than 1 day,

yrs. mos. ds.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore Md

PARENTS.

10-NAME OF FATHER,

Rufus Wilson

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore Md?

12-MAIDEN NAME OF MOTHER

Agnes Smith

13-BIRTHPLACE OF MOTHER
(State or Country),

Calvert Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Archie Brown

(Address)

637 Church St

15-

JUL 29 1915

HARRY O. ANDERSON,

191. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 27

(Month)

(Day)

1915
(Year)

I HEREBY CERTIFY, That I attended deceased from July 26 1915, to July 27 1915, that I saw her alive on July 27 1915, and that death occurred, on the date stated above, at 8:20 p.m.

The CAUSE OF DEATH* was as follows:

Imperforate Rectum
operation, Exhaustion

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. White Pratt M. D.

191... (Address) 358 Montgomery St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn Ct

DATE OF BURIAL,

July 29, 1915

20-UNDERTAKER

J. L. Brown & Son

ADDRESS

108 N. Montg

N. B.—Every item of information should be carefully supplied. AGE, month or years, or years and months. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87033 HEALTH DEPARTMENT—CITY OF BALTIMORE

104
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1331 Bond St.* ST.; *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Grandolyn Johnson*(Residence in Baltimore: No. *1331 Bond St (North)* St.; yrs., *6* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *female*4-COLOR OR RACE, *white*5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *July 27, 1915*7-AGE, *6* yrs., *6* mos. ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....*none*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.

10-NAME OF FATHER, *George M. Johnson*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore Md.*12-MAIDEN NAME OF MOTHER, *Edna E. Cutty*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edna E. Johnson*(Address) *1331 N. Bond St.*

15-

JUL 29 1915

HARRY O. ANDREWS,

Filed..... 1915, *Permit. Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 27, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 27, 1915*, to *July 27, 1915*,that I saw her alive on *July 27, 1915*,and that death occurred, on the date stated above, at *5 P. m.*

The CAUSE OF DEATH* was as follows:

Acute Intestinal Infection(Duration).....yrs.....mos. *2 1/2* ds.CONTRIBUTORY (Secondary) *none*

(Duration).....yrs.....mos.....ds.

(Signed) *Wm H. Braghty* M. D.*July 28, 1915* (Address) *1237 Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery*DATE OF BURIAL, *July 29, 1915*20-UNDERTAKER, *Robt C. Turner*ADDRESS, *1444 Bond St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

JUL 29 1915

HARRY O. ANDREWS,

Baptist Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed) Harry Goldbrg M.D.
7-27, 1915 (Address) 2031 W Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL
COLLEGE OF P. & S.

DATE OF BURIAL

JUL 28 1915

20-UNDERTAKER

ADDRESS

Commissioner Health.

FOR ANATOMICAL PURPOSES

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *119 S. Central Ave* St. *3* WARD)

2-FULL NAME

Jennie Cosentino

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *119 S. Central Ave* St.; yrs. *5* mos. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

*Feb.**22**1915*

(Month)

(Day)

(Year)

7-AGE,

5 yrs. *7* mos. *7* ds.

IF LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Infant*9-BIRTHPLACE,
(State or Country),*Balt.*

10-NAME OF FATHER,

*John Cosentino*11-BIRTHPLACE OF FATHER,
(State or Country),*Italy*

12-MAIDEN NAME OF MOTHER

*Julia Cgeniro*13-BIRTHPLACE OF MOTHER,
(State or Country),*Balt.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Cosentino(Address) *119 S. Central ave.*

15-

*JUL 29 1915**HARRY O. ANDREWS*

Filed

191

Harry O. Andrews
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**29**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 24 1915 to *July 28 1915*that I saw her alive on *July 28 1915*and that death occurred, on the date stated above, at *3 A.m.*

The CAUSE OF DEATH* was as follows:

Intestitis acute(Duration) yrs. mos. *4* ds.CONTRIBUTORY
(Secondary)(Duration) yrs. mos. *2* ds.(Signed) *Wm. L. Ketschick* M. D.*July 29, 1915* (Address) *1038 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Vincent

DATE OF BURIAL,

July 30, 1915

20-UNDERTAKER

ADDRESS

Wendell Wipfel *30 S. Bond St.*

N. B.—Early report of information should be carefully supplied. AGE, MODE OF DEATH, PLACE OF DEATH, and OCCUPATION are very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87042

CERTIFICATE OF DEATH.

151
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1006 Greenmount Ave* ST.; *10* WARD)

2-FULL NAME

Wm J Mattem

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1N.)

(Residence in Baltimore: No. *1006 Greenmount Ave* St.; *1* yrs., *1* mos., *17* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH.

June 17th, 1915
(Month) (Day) (Year)

7-AGE.

1 yrs., *10* mos., *10* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Home*

9-BIRTHPLACE, (State or Country).

Balto Ind

PARENTS.

10-NAME OF FATHER.

Wm J Mattem

11-BIRTHPLACE OF FATHER (State or Country).

Balto Ind

12-MAIDEN NAME OF MOTHER

Mary Shultz

13-BIRTHPLACE OF MOTHER (State or Country).

Balto Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Wm J Mattem

(Address)...

1006 Greenmount

15-

Filed

*JUL 29 1915**HARRY O. ANDREWS,**Marial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 27th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 21, 1915*, to *July 29, 1915*, that I saw him alive on *July 23, 1915*, and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH* was as follows:

Malnutrition(Duration) ... yrs. ... mos. ... *9* ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... *4* ds.

(Signed)

Hustan H. Walters M. D.*July 28, 1915* (Address) *1210 Guilford Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Baltimore Cemetery *July 29, 1915*

20-UNDERTAKER

ADDRESS

John A. Moran *and*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

151 C87043

PLACE OF DEATH
CITY OF BALTIMORE: (No. 1607 Harmon alley ST. 23 WARD)
2-FULL NAME Ellen Koontz
(Residence in Baltimore: No. 1607 Harmon alley St.; yrs. 1 mos. 14 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
6-DATE OF BIRTH June 16 1915
(Month) (Day) (Year)
7-AGE 1 yrs. 14 mos. 14 ds. or min.?
8-OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

JUL 29 1915

HARRY O. ANDREWS

MARIAL PERMIT OFFICE

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17 I HEREBY CERTIFY That I attended deceased from

July 25, 1915, to July 28, 1915,
that I saw him alive on July 26, 1915,
and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Congenital debility

Contributory (SECONDARY)

(Signed)

J. F. Hawkins M. D.
7-29-1915 [Address] 18 Randall St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leslie Hill Cem July 30, 1915

20-UNDERTAKER

ADDRESS

Mrs. J. E. Evans 1428 S. 6th St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *411 N. Guilmore* ST. *19* WARD)

2-FULL NAME *Benjamin J. Johnson*

(Residence in Baltimore: No. *411 N. Guilmore* St. *—* yrs. *—* mos. *—* ds.)

REGISTERED NO. C *120*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Caucas

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

December 1858

(Month)

(Day)

(Year)

7-AGE

57

yrs.

mos.

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

Barker,

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Richmond Va,

10-NAME OF FATHER

Benjamin Johnson

11-BIRTHPLACE OF FATHER

Va,

12-MAIDEN NAME OF MOTHER

Julia McDonald

13-BIRTHPLACE OF MOTHER

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marie Henson

(Address)

Richmond Va

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 27, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from

July 20, 1915 to *July 27, 1915*

that I saw him alive on *July 25, 1915*

and that death occurred, on the date stated above, at *4:30* m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

Contributory (SECONDARY)

Schamberg

(Duration) yrs. mos. *7* ds.

(Duration) yrs. mos. *7* ds.

(Signed) *C. H. Johnson* M. D.

July 29, 1915 (Address) *712 S. Broadway, Va*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Auburn

July 29, 1915

20-UNDERTAKER

ADDRESS

John H. Toadorn *142 W. Hill St*

15. JUL 29 1915

HARRY O. ANDREWS,

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 N. Mount ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nannie E. Buchanan(Residence in Baltimore: No. 1520 N. Mount st St.; 3 yrs., 3 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word.)Infant

6-DATE OF BIRTH,

Apr 17, 1915
(Month) (Day) (Year)

7-AGE,

3 yrs., 3 mos., 11 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Infant9-BIRTHPLACE,
(State or Country),Balto, Md

10-NAME OF FATHER,

James Buchanan11-BIRTHPLACE OF FATHER
(State or Country),Md

12-MAIDEN NAME OF MOTHER

Nannie E. Taylor13-BIRTHPLACE OF MOTHER
(State or Country),Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Gas Buchanan

(Address)

1520 N. Mount

15-

JUL 29 1915 HARRY O. ANDREWS,
Filed....., 191. Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 28, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
July 20 1915 to July 28 1915
that I saw her alive on July 28, 1915,
and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Pneumo-Pneumonia

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

Harry O. Andrews M. D.July 28, 1915, (Address) 1501 Pressman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

St. PetersJuly 28, 1915

20-UNDERTAKER

ADDRESS

Thomas E. Smith 136 W. Carey

N. B.—Every item of information should be carefully supplied. Full names should be written EXACTLY. If informant is not the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87046

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87046

CERTIFICATE OF DEATH.

+ 115

1-PLACE OF DEATH
 CITY OF BALTIMORE: (No. *Ind. Gen. Hosp.* ST. *11* WARD)
 2-FULL NAME *Mrs. Jane Stagner*
 (Residence in Baltimore: No. *Mad. General Hospital* ST. *11* yrs. *—* mos. *28* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widow*
 (Write the word.)
 6-DATE OF BIRTH. *Sept- 11*, 18*46*
 (Month) (Day) (Year)
 7-AGE. *68* yrs. *10* mos. *17* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Nurse*
 (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). *Md*

10-NAME OF FATHER. *Jane Sutton*

11-BIRTHPLACE OF FATHER (State or Country). *Md*

12-MAIDEN NAME OF MOTHER. *Don't know*

13-BIRTHPLACE OF MOTHER (State or Country). *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo. Heath*

(Address) *42 Wilton Heights*

15- *JUL 29 1915*
 Filed..... 191. *HARRY O. ANDREWS*
Marial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 28*, 191*5*.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 21*, 191*5*, to *July 28*, 191*5*, that I saw h. or alive on *July 28*, 191*5*, and that death occurred, on the date stated above, at *8:11 a.m.* The CAUSE OF DEATH* was as follows:

Cholelithiasis
(Cholelithiasis, 1 da.)

(Duration)..... yrs. *6* mos. *1* da.

CONTRIBUTORY. *Acute cardiac dil-*
 (Secondary) *ation & p. o. shock*

(Duration)..... yrs. *1* da.

(Signed)..... *Herbert C. Blake* M. D.

7/28, 191*5*. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. *28* ds. Is the State *68* yrs. *10* mos. *17* ds.

Where was disease contracted, if not at place of death? *Home*

Former or usual residence *42 Wilton Heights, Baltimore*

19-PLACE OF BURIAL OR REMOVAL, *St. Oliver*

DATE OF BURIAL, *July 29*, 191*5*.

20-UNDERTAKER *Chas. E. Branch* ADDRESS *802 Madison St.*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

IF LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

JUL 29 1915

HARRY O. ANDREWS,

Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on and that death occurred, on the date stated above, at 8 a. m. The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE, (No. 846 ul North Ave ST. 13 WARD) REGISTERED No. C
2-FULL NAME William Lemuel Hubbard
(Residence in Baltimore: No. 846 ul North Ave St. 54 yrs. 3 mos. 10 da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. male 4-COLOR OR RACE. white 5-CONVICT, MARRIED, WIDOWED, OR DIVORCED. widow
(Write the word.)
6-DATE OF BIRTH. April 18, 1841
(Month) (Day) (Year)
7-AGE, 74 yrs. 3 mos. 10 da. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Perfume Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer). Perfumes

9-BIRTHPLACE, (State or Country). near Preston (Caroline Co) Md

10-NAME OF FATHER. Lemuel Hubbard

11-BIRTHPLACE OF FATHER (State or Country). near Preston Md

12-MAIDEN NAME OF MOTHER Mary Rumbach

13-BIRTHPLACE OF MOTHER (State or Country). near Preston Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William L. Hubbard

(Address) 846 ul North Ave

15- JUL 29 1915 HARRY O. ANDREWS, 1918 Permit Clerk
Filed 1918 Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1915, to July 28 1915, that I saw h. alive on July 28 1915, and that death occurred, on the date dated above, at 8:30 p.m.
The CAUSE OF DEATH* was as follows:

Atherosclerosis
(Duration) 1 yrs. 3 mos. 10 da.

CONTRIBUTORY Atherosclerosis
(Secondary)
Heart (Duration) 1 yrs. 3 mos. 10 da.
(Signed) J. Frederick Skit M. D.
July 28, 1915 (Address) 20 x 6 Emdor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 3 mos. 10 da. In the State 1 yrs. 3 mos. 10 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Preston Md DATE OF BURIAL, July 29, 1915

20-UNDERTAKER, W. M. Gault ADDRESS 1624 Mt. Vernon Ave

16. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87049

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *St Josephs Hospital* ST. WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and all but No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1603 E. Madison St.* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

May 6, 1865
(Month) (Day) (Year)

7-AGE,

*50 yrs. 2 mos. 21 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*House keeper*

9-BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Samuel Barbour

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Margt Burgan

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. B. L. Gross*(Address) *1603 E. Madison St.*

15-

JUL 29 1915

Filed

191

Baltimore, Md.
Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 21, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 21, 1915* to *July 27, 1915*, that I saw her alive on *July 27, 1915*, and that death occurred, on the date stated above, at *12:20 P.M.*

The CAUSE OF DEATH was as follows:

Typhoid fever(Duration) yrs. mos. ds. *7 ds.*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. *1 ds.*(Signed) *Ernest W. Rogers, M.D.**July 27, 1915* (Address) *St Josephs Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. *7 ds.* In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1603 E. Madison St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Govan's Presby. Cemetery July 28, 1915

20-UNDERTAKER

ADDRESS

Henry Lutz 1007 N. Bond St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.....

1-PLACE OF DEATH

2-CITY OF BALTIMORE: (No.)

3-FULL NAME

(Residence in Baltimore: No.)

ST. WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number and Rm. (not No. 12.)

... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

IF LESS than
1 day, ... hrs.,
... yrs. ... mos. ... ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

JUL 29 1915

ROBERT E. BRAUTER
Baptist Permit Office
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on ... and that death occurred, on the date stated above, at ... P. M.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 W. Montgomery ST.; 22 WARD)

2-FULL NAME

Albert Caesar(Residence in Baltimore: No. 622 W. Montgomery St.; 0 yrs., 0 mos., 0 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE Black 5-SINGLE, MARRIED, OR DIVORCED Single
(Write the word.)6-DATE OF BIRTH, 7 27, 1915
(Month) (Day) (Year)7-AGE, 0 yrs., 0 mos., 0 ds. If LESS than 1 day, 4 hrs. or 30 min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work Name
(b) General nature of industry, business, or establishment in which employed (or employer) Name9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, Wilbert Johnson11-BIRTHPLACE OF FATHER (State or Country), Va.12-MAIDEN NAME OF MOTHER Mabel Caesar13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JUL 29 1915 ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 28, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 7/27 1915, to 7-28 1915, that I saw him alive on 7-27 1915, and that death occurred, on the date stated above, at 3:30 A.M.,

The CAUSE OF DEATH* was as follows:

Congenital dilatation
(Duration) 0 yrs., 0 mos., 0 ds.CONTRIBUTORY
(Secondary)(Signed) R. L. Johnson M. D.
7/29, 1915 (Address) University

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

COLLEGE OF P. & S.JUL 29 191520-UNDERTAKER Commissioner Health

ADDRESS

FOR ANATOMICAL PURPOSES

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *919 W Lexington* ST.; *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Maria Hennegau (Hennegau)(Residence in Baltimore: No. *919 W Lexington* St.; *40* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

March, *1*, *1852*
(Month) (Day) (Year)

7-AGE,

63 yrs. mos. ds.

If LESS than 1 day.

...hrs. or...mins.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE.
(State or Country),*Ireland*

PARENTS.

10-NAME OF FATHER,

*Cornelius Hennegau*11-BIRTHPLACE OF FATHER
(State or Country),*Ireland*

12-MAIDEN NAME OF MOTHER

*Bridget Smyth*13-BIRTHPLACE OF MOTHER
(State or Country),*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Anna Gross*(Address) *2414 Maryland Ave*

15-

Filed

JUL 29 1915

ROBERT KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, *28*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 15 1915 to *July 28* 1915that I saw her alive on *July 28* 1915and that death occurred, on the date stated above, at *12 0* m.

The CAUSE OF DEATH* was as follows:

Acute Gas Intoxication(Duration) yrs. *14* mos. *14* ds.CONTRIBUTORY
(Secondary)(Duration) yrs. *2* mos. *2* ds.(Signed) *S. M. Lempert* M. D.*July 28* 1915 (Address) *826 W. Patterson*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

July 30, 1915

20-UNDERTAKER

H. B. Manning & Son

ADDRESS

517 N Schneider St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 18216 Eager ST. 7 WARD)2-FULL NAME William Vacek

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 18216 Eager St.; yrs., mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Infant (Write the word.)6-DATE OF BIRTH, July 19, 1915
(Month) (Day) (Year)7-AGE, yrs. mos. 10 da. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, John Vacek11-BIRTHPLACE OF FATHER (State or Country), Baltimore12-MAIDEN NAME OF MOTHER Katie Jak13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... John Vacek(Address)..... 18216 Eager St.15- JUL 29 1915 ROBERT KRAUTER,
Filed 11 Barial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 29, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 29, 1915, to July 29, 1915, that I saw him alive on July 29, 1915, and that death occurred, on the date stated above, at 7:10 A m.

The CAUSE OF DEATH* was as follows:

Jaundice
(Duration) Five yrs. mos. ds.

CONTRIBUTORY (Secondary).....

(Duration) Five yrs. mos. ds.(Signed) Walter H. Hark M. D.July 29, 1915 (Address) 1101 13th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Soly RedeemerDATE OF BURIAL, July 30, 191520-UNDERTAKER Frank GrachADDRESS 1904 Highland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. 10 mos. 14 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

July 28, 1915, to, July 29, 1915,

that I saw him alive on July 29, 1915,

and that death occurred, on the date stated above, at 4:23 P.M.

The CAUSE OF DEATH* was as follows:

acute intestinal indigestion

Contributory
(SECONDARY)

(Signed), L. S. Roberts, M.D.
July 29, 1915. [Address] Johns Hopkins Hospital

* State the DISEASE CAUSING DEATH or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. 2 In the State yrs. mos. 2

Where was disease contracted, if not at place of death?

Former or usual residence 502 S. Bentland St

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Marys (Hampden) July 30

20-UNDERTAKER

ADDRESS

Wm A Gerber Baltor

15 JUL 29 1915

Filed 191

ROBERT K. KRAUTER

Burial Permit Clerk

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. 18 WARD)

2 FULL NAME

(Residence in Baltimore: No.

St. 3 yrs. 9 mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ~~STATUS~~

Female White

Widow
(Write the word)

6 DATE OF BIRTH

Aug. 1, 1915
(Month) (Day) (Year)

7 AGE

approx. 65 yrs. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE
(State or country)

Ireland

10 NAME OF FATHER

Thos. B. Hart

11 BIRTHPLACE OF FATHER

Ireland

12 MAIDEN NAME OF MOTHER

Eliz. Curran

13 BIRTHPLACE OF MOTHER

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

JUL 29 1915

ROBERT KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 28, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Apr. 13, 1915, to, July 28, 1915,

that I saw him alive on July 27, 1915,

and that death occurred, on the date stated above, at 7:40 p.m.

The CAUSE OF DEATH* was as follows:

Chronic hyperemia

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory
(SECONDARY)

Pulmonary
tuberculosis

(Duration) 0 yrs. 0 mos. 3 ds.

(Signed) R. K. Krauter M. D.

7/28, 1915 (Address) 1600 Calumet

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Linden Park

July 31, 1915

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1003 W. Baltimore St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 843 Calverton Road ST. WARD)

2-FULL NAME

(Residence in Baltimore: No. 843 Calverton Road yrs. 1 mos. 14 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

June 15, 1915
(Month) (Day) (Year)

7-AGE,

1 yrs. 14 mos. 14 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country),

Balto, Md

10-NAME OF FATHER,

John E. Kelly

11-BIRTHPLACE OF FATHER (State or Country)

Balto, Md.

12-MAIDEN NAME OF MOTHER

Mellie Flynn

13-BIRTHPLACE OF MOTHER (State or Country),

Balto, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E. Kelly(Address) 843 Calverton Road

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 29, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from July 26, 1915 to July 29, 1915, that I saw him alive on July 29, 1915, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis(Duration) 4 yrs. 4 mos. 4 ds.CONTRIBUTORY (Secondary) Artificially(Duration) 4 yrs. 4 mos. 4 ds.(Signed) John E. Kelly M. D.July 29, 1915 (Address) 1003 Lehigh Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 14 mos. 14 ds. In the State 1 yrs. 14 mos. 14 ds.Where was disease contracted? 843 Calverton RoadFormer or usual residence 843 Calverton Road

19-PLACE OF BURIAL OR REMOVAL

St. Peter's Cemetery

DATE OF BURIAL,

July 30, 1915

20-UNDERTAKER

W. J. Flynn

ADDRESS

1422 Highland

15-

JUL 29 1915

ROBERT KRAUTH,

Filed 1915 Burial Permit Clerk

Registrar.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3654 Railroad Ave.* ST. *13* WARD)

2-FULL NAME

(Residence in Baltimore: No. *3654 Railroad Ave.* St. *13* yrs. — mos. — ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*Widow*

6-DATE OF BIRTH,

May 4, 1847
(Month) (Day) (Year)

7-AGE,

68 yrs. 2 mos. 25 ds.
If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*At Home*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Louise Hodiste

(Address)

3654 Railroad Ave.

15-

*JUL 29 1915**ROBERT J. KRAUTER,*
Morial Permit Clerk

Filed..... 191

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 29, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 16, 1915* to *July 29, 1915*, that I saw her alive on *July 27, 1915*, and that death occurred, on the date stated above, at *2:10 A.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Chronic Hypertension*

(Duration)..... yrs. mos. ds.

(Signed) *Joseph D. ...* M. D.*July 29, 1915* (Address) *846 E. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cockeysville, Md. July 31, 1915

20-UNDERTAKER

ADDRESS

Horace Burgeon 363 Falls Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *745 McHenry* ST.; *21* WARD)

2-FULL NAME

(Residence in Baltimore: No. *745 McHenry* St.; *1* yrs., *7* mos. *21* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*WCT*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Mar*

6-DATE OF BIRTH,

Dec 7, 1913
(Month) (Day) (Year)

7-AGE,

1 yrs., *7* mos., *21* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Bald Md

10-NAME OF FATHER,

Joseph Drummond

11-BIRTHPLACE OF FATHER

(State or Country),

Washington DC

12-MAIDEN NAME OF MOTHER

Agnes C. Seibel

13-BIRTHPLACE OF MOTHER

(State or Country),

Bald Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

May E. Koyne

(Address).....

Lawrence

15-

Filed

*JUL 30 1915**HARRY O. ANDREWS*
Marial Permit Office

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 28, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 18, 1915, to *July 28, 1915*;that I saw him alive on *July 28, 1915*;and that death occurred, on the date stated above, at *11:15* a.m.

The CAUSE OF DEATH* was as follows:

Contributory(Duration)..... yrs..... mos. *10* ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos. *1* ds.

(Signed)..... M. D.

July 29, 1915 (Address)..... *517 L...*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*London Park**Aug. 30 1915*

20-UNDERTAKER

ADDRESS

Geo. Louis ...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *842 Tessier St.*)ST.: *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Robert Welch(Residence in Baltimore: No. *802 Tressie St.*)St.; yrs. *10* mos. *8* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

colored

5-SINGLE

single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Oct 21, 1914
(Month) (Day) (Year)

7-AGE,

10 yrs. *8* mos. *8* da.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Balto

10-NAME OF FATHER,

Wm Welch

11-BIRTHPLACE OF FATHER (State or Country),

Balto

12-MAIDEN NAME OF MOTHER

Minnie Butler

13-BIRTHPLACE OF MOTHER (State or Country),

Conrad Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Minnie Welch

(Address)...

802 Tressie St.

15-

JUL 30 1915 HARRY O. ANDREWS,
Filed Serial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 29, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 27, 1915* to *July 28, 1915*, that I saw him alive on *July 27, 1915*, and that death occurred, on the date stated above, at *6:30 a. m.*

The CAUSE OF DEATH* was as follows:

Diphtheria(Duration).... yrs. mos. *2* da.

CONTRIBUTORY (Secondary)

(Duration).... yrs. mos. da.

(Signed) *E. H. Hutchins* M. D.101... (Address) *1230 Light St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

W. A. Hutchins *July 29, 1915*

20-UNDERTAKER

ADDRESS

Wm. Carter Remman
E. H. Hutchins M. D.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Vincent's Infirmary*)ST.: *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John Cabert(Residence in Baltimore: No. *St. Vincent's Infant Asylum*)St.: yrs., *1* mo., *19* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) *Single*

6-DATE OF BIRTH,

May 16, 1915
(Month) (Day) (Year)

7-AGE,

*2 mos. 10 ds.*If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, business,
or establishment in which
employed (or employer).....*None*9-BIRTHPLACE,
(State or Country),*England*

PARENTS.

10-NAME OF
FATHER,*Unknown*11-BIRTHPLACE
OF FATHER
(State or Country),*Unknown*12-MAIDEN NAME
OF MOTHER*Unknown*13-BIRTHPLACE
OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St*

15-

*JUL 30 1915**HARRY O. ANDREWS,*Filed..... 191... *Barlet Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 26, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1st 1915, to *July 26 1915*,that I saw him alive on *July 26 1915*,and that death occurred, on the date stated above, at *yes* m.

The CAUSE OF DEATH* was as follows:

Malnutrition and
Mal-assimilation
(Duration) yrs. *1* mo. *10* ds.CONTRIBUTORY
(Secondary)(Duration) yrs. *1* mo. *10* ds.(Signed) *J. E. Poulton* M. D.*July 27, 1915*. (Address) *615 Columbia Ave*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mo. *19* ds. In the State yrs. *2* mo. *10* ds.Where was disease contracted,
if not at place of death?Former or usual residence *St Vincent's Infant Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Catholic Burial Ground July 30 1915

20-UNDERTAKER

ADDRESS

Marlin Frakes 606 Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asy.* ST.; *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Gregory Edwards(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; — yrs. *1* mos. *17* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

June 11th, 1915
(Month) (Day) (Year)

7-AGE,

1 mos. 17 ds.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country), *Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

Filed

*JUL 30-1915**HARRY O. ANDREWS,**Burial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH,

July 28, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1, 1915*, to *July 27, 1915*, that I saw him alive on *July 27, 1915*, and that death occurred, on the date stated above, at *5:30 a.m.*

The CAUSE OF DEATH* was as follows:

*M. abnutrition and
M. al-assimilation*(Duration) *1 mos. 17 ds.*CONTRIBUTORY
(Secondary)(Duration) *1 mos. 17 ds.*(Signed) *J. E. Poulton* M. D.*July 28, 1915* (Address) *615 Columbia Ave.
per John A. M. M. M.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death *1 mos. 17 ds.* In the State *1 mos. 17 ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

St. Vincent's Infant Asylum

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Leathhead Lane**July 30, 1915*

20-UNDERTAKER

ADDRESS

Marion S. Shepherd, 606 Lafayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Julianna Adams(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; — yrs., *1* mos. *23* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

June 5th, 1915
(Month) (Day) (Year)

7-AGE,

1 mos. 23 ds.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

Filed

JUL 30 1915

HARRY O. ANDREWS

Serial Permit. 010

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 28, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1* 1915, to *July 28* 1915, that I saw her alive on *July 28* 1915, and that death occurred, on the date stated above, at *9:30 P. M.*

The CAUSE OF DEATH* was as follows:

M. tuberculosis(Duration) ... yrs. *1* mos. ... ds.CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *J. E. Poulton* M. D.*July 28, 1915* (Address) *615 Columbian Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *23* ds. In the State yrs. *1* mos. *23* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

St Vincent's Infant Asylum

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

*Cathedral**July 30 1915*

20-UNDERTAKER

ADDRESS

Martin Baker Day 600 Lafayette Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.: *14* WARD)

REGISTERED NO. C.

2-FULL NAME

Helen Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: *14* yrs. *2* mos. *21* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

April
(Month)*6*, *1915*
(Day) (Year)

7-AGE,

3 yrs. *2* mos. *21* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*None*

9-BIRTHPLACE, (State or Country),

England

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

Filed

JUL 30 1915

HARRY O. ANDREWS,

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July *27*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1 *1915*, to *July 27* *1915*,that I saw her alive on *July 27* *1915*,and that death occurred, on the date stated above, at *1:30 P. M.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) *3* yrs. *2* mos. *21* ds.

CONTRIBUTORY (Secondary)

Malnutrition(Duration) *2* yrs. *2* mos. *21* ds.

(Signed)

J. E. Poulton M. D.*July 27, 1915* (Address) *615 Columbia Ave.*
per John A. Marshall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs. *2* mos. *21* ds. In the State *3* yrs. *2* mos. *21* ds.Where was disease contracted, if not at place of death? *St. Vincent's Infant Asylum*Former or usual residence *St. Vincent's Infant Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Seathurst Ave**July 29 1915*

20-UNDERTAKER

ADDRESS

Martin A. Hepburn 606 Lafayette Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87064

C87064

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

37
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

FILED

JUL 30 1915

HARRY O. ANDREWS

Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of Certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1. day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed), Harry Goldstein

7-29, 1915 (Address) 2031 W. Park St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 4 mos. ds. State

Where was disease contracted? Nursery & Child Hospital

If not at place of death? Nursery & Child Hospital

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

JUL 30 1915

HARRY O. ANDREWS,

Filed, 1915 Serial Permit 0141 REGISTRAR

Geo. J. Smith

1000 W. Fayette St.

See Birth Certificate of Baby Wade?

Infant of Mamie & Joseph Wade,
Born April 11th. 1915
B-11065

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Mc Eldeny ST.; 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertie Hymene

(Residence in Baltimore: No. 1408 Mc Eldeny St St.: yrs. 3 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Caucasian

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

April 11, 1915
(Month) (Day) (Year)

7-AGE,

yrs. 3 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

BIRTHPLACE,

(State or Country),

Balto.

10-NAME OF FATHER,

Joseph Hymene

11-BIRTHPLACE OF FATHER

(State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Mamie Hymene

13-BIRTHPLACE OF MOTHER

(State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Hymene

(Address) 1408 Mc Eldeny St

15- JUL 30 1915 HARRY O. ANDREWS,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 4, 1915, to July 29, 1915.

that I saw h or alive on July 29, 1915.

and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pertussis

(Duration) yrs. mos. ds.

(Signed) R. L. Lohman M. D.

July 30, 1915 (Address) 611 N. Carroll St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Laurel Cemetery July 31, 1915.

20-UNDERTAKER, ADDRESS

R. B. Gross 1405 Mc Eldeny St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87068

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

37 C87068
REGISTERED No. C

1-PLACE OF DEATH *Nursery - Child*

CITY OF BALTIMORE (No. *Frederick Schradt*)

2-FULL NAME *James Vincent*

(Residence in Baltimore: No. *Frederick Schradt*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

June 11, 1915
(Month) (Day) (Year)

7-AGE

1 yrs. *19* mos. *19* ds. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Unknown

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER (State or country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nursery - Child

(Address)

15-

JUL 30 1915

HARRY O. ANDREWS,

Serial Permit No. 1000

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 29, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 29, 1915, to *July 29, 1915*,

that I saw him alive on *July 29, 1915*,

and that death occurred, on the date stated above, at *1 P.m.*

The CAUSE OF DEATH* was as follows:

Decomposition

Contributory (SECONDARY)

1 yrs. *11* mos. *11* ds.

(Signed)

Harry Goldberger M. D.

7-29, 1915 (Address) *2031 W. Pratt*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *1* yrs. *4* mos. *4* ds. In the State *1* yrs. *4* mos. *4* ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

COLLEGE OF P. & S.

DATE OF BURIAL

JUL 30 1915

20-UNDERTAKER

Commissioner Health.

ADDRESS

FOR ANATOMICAL PURPOSES

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *103 W. Randall* ST. *28* WARD)REGISTERED NO. *170*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *103 W. Randall* St.; *28* yrs., *0* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Unknown 1887
(Month) (Day) (Year)

7-AGE,

28

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Batts. Ind.*10-NAME OF FATHER, *Joe Hennessy*11-BIRTHPLACE OF FATHER (State or Country), *Ind.*12-MAIDEN NAME OF MOTHER *Mrs. Newman*13-BIRTHPLACE OF MOTHER (State or Country), *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Becky Hennessy*(Address) *1449 Patapsco*

15-

JUL 30 1915. HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 28th 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 20th 1915*, to *July 28th 1915*, that I saw her alive on *July 28th 1915*, and that death occurred, on the date stated above, at *7:15 P.M.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) *?* yrs. *?* mos. *?* ds.CONTRIBUTORY (Secondary) *Hypertension & arterio-sclerosis*(Duration) *?* yrs. *?* mos. *?* ds.(Signed) *John S. Zinner* M. D.*July 28 1915* (Address) *Ardenway, Ind.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *8* yrs. *0* mos. *0* ds. In the *28* yrs. *0* mos. *0* ds.Where was disease contracted, if not at place of death? *—*Former or usual residence *103 W. Randall St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Ave. July 31, 1915

20-UNDERTAKER

ADDRESS

St. John's Church 1018 E. 1st St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87070

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 803 Plum Alley

ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Williams Rollins

(Residence in Baltimore: No.

803 Plum Alley

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

June 18, 1915
(Month) (Day) (Year)

7-AGE,

yrs. 1 mos. 10 ds.

IF LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Balto Md

10-NAME OF FATHER,

B Rollins

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Amey Ebb

13-BIRTHPLACE OF MOTHER

(State or Country),

Calvert Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Amey Ebb

(Address) 803 Plum Alley

15-

Filed

JUL 30 1915

HARRY O. ANDREWS,

191. Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 28, 1915.
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry
(Inquest, au-

topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastritis

(Duration) yrs. Unknown ds.

CONTRIBUTORY Exhaustion
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. E. Scott M. D.
(Coroner.)

July 28 1915 (Address) 517 Scott

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

COLLEGE OF P. & S.

DATE OF BURIAL,

JUL 30 1915

20-UNDERTAKER

Commissioner Health.

ADDRESS

FOR ANATOMICAL PURPOSES.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 E. Madison ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Precilla Tubman(Residence in Baltimore: No. 1508 E. Madison St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Unknown, 1.....
(Month) (Day) (Year)

7-AGE,

50 yrs..... mos..... ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),Balto. Md.

10-NAME OF FATHER,

Thomas Ross11-BIRTHPLACE OF FATHER
(State or Country),Md.

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUL 30 1915 HARRY O. ANDREWS,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 28, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 15, 1915, to July 28, 1915,that I saw her alive on July 27, 1915,and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Gastric catarrh.

.....

.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

July 28, 1915 (Address) 611 N. Broadway, St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Int. African Cemetery July 30, 1915.

20-UNDERTAKER

ADDRESS

Chas & Bailey Jefferson St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *4* WARD)2-FULL NAME *George Summs*(Residence in Baltimore: No. *University Hospital* St.; — yrs., — mos. *7* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *White*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *March 4, 1871*

(Month)

(Day)

(Year)

7-AGE, *44* yrs. *4* mos. *5* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Suburban*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country), *Ind.*10-NAME OF FATHER, *George Summs*

11-BIRTHPLACE OF FATHER

(State or Country), *Ind.*12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER

(State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Mellin*(Address) *Ellicott City, Md.*

15-

JUL 30 1915

HARRY O. ANDREWS,

191.....Burial Permit.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 29, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 22, 1915*, to *July 29, 1915*, that I saw him alive on *July 29, 1915*, and that death occurred, on the date stated above, at *11:50 p.m.*

The CAUSE OF DEATH* was as follows:

Dysphagia, Food.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) *Stomach*

(Duration).....yrs.....mos.....ds.

(Signed) *W. H. H. H.*

M. D.

7/29, 1915. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *7* ds. In the State *Ind.* yrs. mos. ds.Where was disease contracted, if not at place of death? *Ellicott City, Ind.*Former or usual residence *Ellicott City, Ind.*

19-PLACE OF BURIAL OR REMOVAL,

PLACE OF BURIAL,

*Ellicott City Cemetery**July 30, 1915*20-UNDERTAKER *Balto Co. Rd.*

ADDRESS

*Easton Sons**Ellicott City*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *1357 Woodyear*)

ST. *15* WARD)

2-FULL NAME *Bernard Smith Jr.*

(Residence in Baltimore: No. *1357 Woodyear*)

St. yrs. *2* mo. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*

6-DATE OF BIRTH *May 20, 1915*
(Month) (Day) (Year)

7-AGE *2* yrs. *10* mos. *10* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) *-none-*

9-BIRTHPLACE (State or country) *Md. Balto City*

10-NAME OF FATHER *Bernard Smith Jr.*

11-BIRTHPLACE OF FATHER (State or country) *Md.*

12-MAIDEN NAME OF MOTHER *Hilda Hall*

13-BIRTHPLACE OF MOTHER (State or country) *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harriet H. Hall*

(Address) *1357 Woodyear St.*

15 JUL 30 1915

HARRY O. ANDREWS

Sanial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 30, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *7/20*, 1915, to *7/30*, 1915

that I saw *h* alive on *7/29*, 1915, and that death occurred, on the date stated above, at *301* M.

The CAUSE OF DEATH* was as follows:

An gastric enteritis

(Duration) yrs. mos. *10* ds.

Contributory (SECONDARY) *Toxemia & pneumonia*

(Duration) yrs. mos. *3* ds.

(Signed) *B. M. Phillips* M. D.

7/30, 1915 (Address) *215 S. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenwood Cemetery

July 31, 1915

20-UNDERTAKER

ADDRESS

Sam'l H. Chase & Son

1400 Mosby

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2521 Emerson*)

2-FULL NAME

(Residence in Baltimore: No. *2521 Emerson*)

REGISTERED NO. C

ST. *30* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *2* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6-DATE OF BIRTH

Dec. 15, 1859
(Month) (Day) (Year)

7-AGE

55 yrs. *7* mos. *13* ds. *—* If LESS than 1 day, *—* hrs. or *—* min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Railway Motorman

9-BIRTHPLACE (State or country)

Maryland

10-NAME OF FATHER

Aug. Ohle

11-BIRTHPLACE OF FATHER (State or country)

Germany

12-MAIDEN NAME OF MOTHER

Wilhelmina Tappan

13-BIRTHPLACE OF MOTHER (State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sadie Ohle

(Address)

2521 Emerson St

15-

JUL 30 1915

HARRY O. ANDREWS,

DEPUTY REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 28, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 15, 1915, to, *July 28, 1915*.

that I saw him alive on *July 27, 1915*.

and that death occurred, on the date stated above, at *5 P. m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory (SECONDARY)

Cardiac Asthenia
(Duration) *2* yrs. *—* mos. *—* ds.

(Signed)

G. A. Shiede
July 29, 1915 (Address) *1530 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from violent causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Oak Lawn

DATE OF BURIAL

July 31, 1915

20-UNDERTAKER

George Lehman 1320 2101 Frederick Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087075		HEALTH DEPARTMENT—CITY OF BALTIMORE		1		087075	
PLACE OF DEATH				CERTIFICATE OF DEATH			
CITY OF BALTIMORE (No. <u>735 S. Monford Ave.</u>)				REGISTERED No. C <u>1</u>			
2-FULL NAME <u>Stanislaus Urbanski</u>				(If death occurred in a hospital or institution, give its NAME instead of street and number and full out No. 13.)			
(Residence in Baltimore: No. <u>735 S. Monford Ave.</u> St. <u>13</u> yrs. <u>4</u> mos. <u>ds.</u>)							
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH			
3-SEX <u>Male</u>	4-COLOR OR RACE <u>White</u>	5-SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u>		16-DATE OF DEATH <u>July 29, 1915</u>			
6-DATE OF BIRTH <u>June 14, 1886</u>				(Month) (Day) (Year)			
7-AGE <u>29</u> yrs. <u>1</u> mos. <u>13</u> ds.				17. I HEREBY CERTIFY, That I attended deceased from <u>June 29, 1915</u> to <u>July 29, 1915</u> , that I saw him alive on <u>July 28, 1915</u> , and that death occurred, on the date stated above, at <u>5:30</u> m. The CAUSE OF DEATH* was as follows:			
8-OCCUPATION <u>Fireman, Tax room</u>							
(a) Trade, profession, or particular kind of work <u>Copper Smelting</u>							
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Boeing Corp.</u>							
9-BIRTHPLACE (State or country) <u>Poland</u>							
10-NAME OF FATHER <u>Stanislaus Urbanski</u>				Contributory (SECONDARY) <u>Stanislaus Urbanski</u>			
11-BIRTHPLACE OF FATHER (State or country) <u>Poland</u>				(Duration) yrs. <u>1</u> mos. <u>23</u> ds.			
12-MAIDEN NAME OF MOTHER <u>Anna Olinska</u>				(Duration) yrs. <u>1</u> mos. <u>23</u> ds.			
13-BIRTHPLACE OF MOTHER (State or country) <u>Poland</u>				(Signed) <u>Stanislaus Urbanski</u> M. D.			
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Catharine Urbanski</u>				*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
(Address) <u>735 S. Monford Ave.</u>				18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)			
15 <u>JUL 3 1915</u> <u>ROBERT KRAUTER</u> , REGISTRAR				At place of death <u>St. Stanislaus</u> In the <u>State</u> yrs. <u>1</u> mos. <u>23</u> ds.			
				Where was disease contracted, <u>St. Stanislaus</u>			
				If not at place of death? <u>Former or usual residence</u>			
				19-PLACE OF BURIAL OR REMOVAL <u>St. Stanislaus</u>			
				20-UNDERTAKER <u>M. J. Sadowski</u>			
				DATE OF BURIAL <u>July 31, 1915</u>			
				ADDRESS <u>705 S. Ann St.</u>			

ALL INFORMATION SHOULD BE CAREFULLY SUPPLIED. ALL SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1576 E Madison*)

2-FULL NAME

Evelyn K Ruff

(Residence in Baltimore: No. *1576 E Madison*)

St.:

7

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., *1* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

Married

Widowed

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

June

29th, 1914

(Month)

(Day)

(Year)

7-AGE,

1 yrs. *1* mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

Infant

9-BIRTHPLACE,

(State or Country).

md

10-NAME OF FATHER,

Charles Ruff

11-BIRTHPLACE OF FATHER

(State or Country).

md

12-MAIDEN NAME OF MOTHER

Mary Davis

13-BIRTHPLACE OF MOTHER

(State or Country).

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Ruff

(Address)

1576 E. Madison St.

15-JUL 31 1915

ROBERT KRAUTER,

Filed

191

Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 29th, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*

(Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said

Inquest and that said deceased came to her death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Inanition Natural causes

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Elizabet J. Russell* M. D.

(Coroner)

July 30th, 1915 (Address) *425 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Asbury Cem.

DATE OF BURIAL,

July 31, 1915

20-UNDERTAKER

Wm. G. Locke

ADDRESS

1302 Jefferson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Edward J. Roles.
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Jackson's Wharf front of Caroline* ST.: *3* WARD)

2-FULL NAME

(Residence in Baltimore: No. *106 S. Bethel* St.: yrs., *Life* mos. ds.)

REGISTERED No. C. *169*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Caucas

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

October
(Month)

25, 1892
(Day) (Year)

7-AGE,

22 yrs., *9* mos., *6* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer
General

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

Edward Rose

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Isabella Thomas

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Isabella Rose*

(Address) *106 S. Bethel St.*

15-

JUL 31 1915

ROBERT . KRAUTER,

191... Serial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July
(Month)

28, 1915.
(Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an...
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said...
(Inquest, au-

...and that said deceased came to death...
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Ed. Jones* M. D.

(Coroner)

July 29, 1915 (Address) *3116 O. Avenue*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

St. Auburn

DATE OF BURIAL,

Aug 1, 1915

20-UNDERTAKER

Theodore White

ADDRESS

1702 E. Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hosp for the Women of Ind.

CITY OF BALTIMORE: No. Lafayette and John STS. 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Jarrett

(Residence in Baltimore: No. 2013 W. Balto. St.

St.: 5 yrs., \ mos. \ ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-~~SINGLE~~
MARRIED, Unmarried
~~WIDOWED~~
~~OR DIVORCED~~
(Write the word.)

6-DATE OF BIRTH,

May 17

1884

(Month)

(Day)

(Year)

7-AGE,

31 yrs. 2 mos. 13 ds.

If LESS than 1 day,

hrs. of min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,
(State or Country),

Chesnut Ridge Maryland

10-NAME OF FATHER,

Conrad Zink

11-BIRTHPLACE OF FATHER
(State or Country),

Balto. Co.

12-MAIDEN NAME OF MOTHER

Pauline E. Wand

13-BIRTHPLACE OF MOTHER
(State or Country),

Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Wm. M. Zink

(Address) Cockeysville P. D.

15-

Filed

JUL 31 1915

ROBERT . KRAUTH

Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 30

(Month)

(Day)

1915 (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 22 1915, to July 30 1915,

that I saw her alive on July 30 1915,

and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:

Pyelitis and Appendicitis

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY Peritonitis
(Secondary)

(Duration) yrs. mos. 2 ds.

(Signed) A. P. Jones M. D.

July 30, 1915 (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 8 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2013 Balto. St. City

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Solis Ave Balto

Aug 1, 1915

20-UNDERTAKER

ADDRESS

John Burston Torrey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87079

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87079

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *821* *Edmondson* ST. *17* WARD)

2-FULL NAME *Wm. Brooks*

(Residence in Baltimore: No. *821 Edmondson Ave* St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

July 29, 1915
(Month) (Day) (Year)

7-AGE

If LESS than

1 day, hrs.

or 40 min.?

yrs. mos. ds.

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

none

9-BIRTHPLACE

(State or country)

Balto Md.

10-NAME OF FATHER

James M Brooks

11-BIRTHPLACE OF FATHER

(State or country)

Balto

12-MAIDEN NAME OF MOTHER

Babette Wicks

13-BIRTHPLACE OF MOTHER

(State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James M Brooks

(Address)

821 Edmondson Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That attended deceased from

July 29, 1915, to *July 27, 1915*,

that I saw him alive on *July 27, 1915*,

and that death occurred, on the date stated above, at *11:40 a.m.*

The CAUSE OF DEATH* was as follows:

per acute dilated

6 1/2 no gestation
(Duration) yrs. mos. ds.

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

H E Humph

July 30, 1915 [Address] *1002 N. Lammah*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holly Becker

7-31, 1915

20-UNDERTAKER

ADDRESS

H. B. Manning & Co. Edmondson Ave

JUL 31 1915

ROBERT KRAUTER,

Burial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87080

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1731, Lancaster* ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

2-FULL NAME

(Residence in Baltimore: No. *1731, Lancaster* St.;yrs., *2* mos. *23* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

May 7, 1915
(Month) (Day) (Year)

7-AGE.

2 yrs., 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None.*

9-BIRTHPLACE, (State or Country).

Baltimore Md.

10-NAME OF FATHER.

John Wagner.

11-BIRTHPLACE OF FATHER (State or Country).

Germany.

12-MAIDEN NAME OF MOTHER

Mary Rezulak.

13-BIRTHPLACE OF MOTHER (State or Country).

Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Wagner.*(Address) *1731, Lancaster St.*

15-JUL 31 1915

ROBERT KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 30, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 26, 1915*, to *July 30, 1915*, that I saw her alive on *July 30, 1915*, and that death occurred, on the date stated above, at *5:45* m.

The CAUSE OF DEATH* was as follows:

Malaria
went up breast neck
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

artificially fed
(Duration).....yrs.....mos.....ds.(Signed) *J. J. Valentini* M. D.*July 30, 1915* (Address) *16 S. Brady*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the.....yrs.....mos.....ds. State.....

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

St. Stanislaus

DATE OF BURIAL.

July 31, 1915

20-UNDERTAKER.

M. F. Sadowski

ADDRESS

705 S. Ann St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *617 S. Patterson Park Ave* ST.: *1* WARD)

FULL NAME

Peter J. Kobylakiewicz

(Residence in Baltimore: No. *617 S. Patterson Park Ave* St.: yrs., *2* mos. — ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

....., *1876*
(Month) (Day) (Year)

7-AGE,

39 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Sailor

(b) General nature of industry, business, or establishment in which employed (or employer).

General

9-BIRTHPLACE,

(State or Country),

Austria

10-NAME OF FATHER,

Walter J. Kobylakiewicz

11-BIRTHPLACE OF FATHER

(State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lillian J. Kobylakiewicz*

(Address) *617 S. Patterson Park Ave*

15-

Filed

JUL 31 1915

ROBERT J. KRAUTER

Morial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 30th, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said
(Inquest, au-

..... and that said deceased came to death
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. Jones* M. D.
(Coroner.)

July 30th, 1915 (Address) *3116 Vismuell St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Any*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Stanislaus

July 2nd, 1915

20-UNDERTAKER

ADDRESS

M. F. Sadowski 705 N. ...

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87082

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

921 S Kenwood St.; 1st WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary Wilson

(Residence in Baltimore: No.

921 S Kenwood Ave. St.: 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED, Widowed,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Dec

14

1891

(Month)

(Day)

(Year)

7-AGE,

73

7

mos. 15 ds.

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Holland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. W. Wilson

(Address) 1108 Patuxent St.

15-

JUL 31 1915

ROBERT KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

29

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 8th 1915, to July 29th 1915.that I saw her alive on July 29th 1915,

and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Val disease Heart chronic

(Duration) yrs. 4 mos. 15 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. N. Olney, M. D.

July 30th 1915 (Address) 100 S. Patuxent St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mount Carmel

Aug 1, 1915

20-UNDERTAKER

ADDRESS

Peter Nicolaus

2144 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *2018 E Lanvale St.*)

WARD

FULL NAME

(Residence in Baltimore: No. *2018 E Lanvale St.*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow

6-DATE OF BIRTH

May 6, 1845

7-AGE

70 yrs. 2 mos. 23 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or country) *Germany*

10-NAME OF FATHER

Adam Willey

11-BIRTHPLACE OF FATHER

(State or country) *Germany*

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or country) *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Crenitz
2018 E. Lanvale St.

15.

JUL 31 1915

W. KRAUTER,
Sanial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 29, 1915

17. I HEREBY CERTIFY, That I attended deceased from *Jan 24, 1915* to *July 28, 1915*, that I saw her alive on *July 28, 1915*, and that death occurred, on the date stated above, at *7 A. m.* The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

Contributory (SECONDARY)

(Duration) *1* yrs. *1* mos. *1* ds.

(Signed)

July 29, 1915 (Address) *1601 Lexington St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *1* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

July 31, 1915

20-UNDERTAKER

Henry Lutz

ADDRESS

1007 N. Bond St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hoop* ST.; *17* WARD)2-FULL NAME *Fannie Smith*(Residence in Baltimore: No. *517 W. Bidale* Life Time yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Black*5-SINGLE, *widowed*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *unknown*, 1851

(Month)

(Day)

(Year)

7-AGE, *64* yrs. mos. ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balto Md*10-NAME OF FATHER, *Oliver Dorsey*11-BIRTHPLACE OF FATHER (State or Country), *Md*12-MAIDEN NAME OF MOTHER, *Emily Harris*13-BIRTHPLACE OF MOTHER (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss M.A. & Phillip*(Address) *517 W Bidale*

15-

JUL 31 1915

ROBERT

KRAUTH

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 30*, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 23* 1915, to *July 30* 1915, that I saw her alive on *July 30* 1915, and that death occurred, on the date stated above, at *3 P.* m. The CAUSE OF DEATH* was as follows:*Senile & aneurysm of*
heart & leg
(Duration) *unknown* yrs. mos. ds.CONTRIBUTORY (Secondary) *Arteriosclerosis*(Signed) *W. Houston* M. D.
July 30, 1915. (Address) *Univ Hoop*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *10* ds. In the *60* yrs. mos. ds.Where was disease contracted, if not at place of death? *unknown*Former or usual residence *517 W. Bidale St*19-PLACE OF BURIAL OR REMOVAL, *Laurel Cemetery*DATE OF BURIAL, *Aug 1*, 1915

20-UNDERTAKER

*Chas E. Tranch*ADDRESS *802 Madison*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87085

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 87085

S

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.

120 King's Court

ST.

WARD

2-FULL NAME

Cordella Ann Wilson

(Residence in Baltimore: No.

120 King's Court

St.

Yrs.

mos.

ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 11.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

unknown

(Month)

(Day)

(Year)

7-AGE

58

Yrs.

mos.

ds.

If LESS than
1 day, hrs.,

min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

General

9-BIRTHPLACE
(State or country)

Balt. city

PARENTS

10-NAME OF FATHER

John Hanson

11-BIRTHPLACE OF FATHER
(State or country)

Balt city

12-MAIDEN NAME OF MOTHER

Cordella Hanson

13-BIRTHPLACE OF MOTHER
(State or country)

Balt city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frances Hanson

(Address)

416 Dover

MEDICAL CERTIFICATE OF DEATH

15-DATE OF DEATH

July 28, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY That I attended deceased from July 18, 1915, to July 28, 1915, that I saw her alive on July 28, 1915, and that death occurred, on the date stated above, at 4 P.M. The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration)

Yrs.

mos.

ds.

Contributory
(SECONDARY)

(Duration)

Yrs.

mos.

ds.

(Signed)

Harry Bryd

M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death Yrs. mos. ds. State Yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Int Auburn Cemetery

DATE OF BURIAL

July 31, 1915

20-UNDERTAKER

Geo L Hooper

ADDRESS

609 Little Rock

JUL 31 1915

Filed 1915

HARRY O. ANDREWS

Serial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1333 Whitcomb ST. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Lewis(Residence in Baltimore: No. 1333 Whitcomb St. 6 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH,

Unknown1897

(Month)

(Day)

(Year)

7-AGE,

64

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired

9-BIRTHPLACE,

(State or Country)

Charles Co. Md

10-NAME OF FATHER

George Lewis

11-BIRTHPLACE OF FATHER

(State or Country)

Charles Co. Md

12-MAIDEN NAME OF MOTHER

Caroline Harris

13-BIRTHPLACE OF MOTHER

(State or Country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Mary Lewis(Address) 1333 Whitcomb St

15-

JUL 31 1915
Filed..... 1915

BENNY O. ANDREWS,

Chief Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 30, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from July 27, 1915, to July 30, 1915, that I saw him alive on July 30, 1915, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

Arterio Sclerosis

(Signed)

Dr. H. W. HughesJuly 30, 1915 (Address) 1259 W. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Peter's

DATE OF BURIAL,

Aug. 1, 1915

20-UNDERTAKER

James E. Murphy

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 503 S Bond St. ST. 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Hofmeister(Residence in Baltimore: No. 003 S Bond StSt.; — yrs., — mos., — da.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED, Widowed
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 13, 1886
(Month) (Day) (Year)

7-AGE,

29 yrs., 1 mos., 16 da.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Store GroceryHelper9-BIRTHPLACE,
(State or Country).Germany

10-NAME OF FATHER,

John Selig11-BIRTHPLACE OF FATHER
(State or Country).Germany

12-MAIDEN NAME OF MOTHER

Ant. Kuntz13-BIRTHPLACE OF MOTHER
(State or Country).Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hofmeister(Address) 003 S Bond St.

15-JUL 31 1915

HARRY O. ANDREWS,

Filed..... 191... Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 19 1915, to July 29 1915,that I saw h — alive on July 29 1915,and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pneumo - Pneumonia(Duration) 10 da.CONTRIBUTORY Senility —
(Secondary)(Duration) — yrs., — mos., — da.(Signed) Wm. C. Bussell M. D.July 30, 1915. (Address) 125 S. Howard —

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — da. In the State — yrs., — mos., — da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore CountyJuly 31 1915

20-UNDERTAKER

ADDRESS

Wendell Clapp & Son 322 E. Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87088

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87088

CERTIFICATE OF DEATH

1 PLACE OF DEATH

324 N. Pulaski St

45 REGISTERED No. C

CITY OF BALTIMORE (No. ~~Mary E. Carr~~)

ST 70

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

Mary E. Carr

(Residence in Baltimore: No. 324 N. Pulaski

St. — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Dec 8, 1870
(Month) (Day) (Year)

7 AGE

44 yrs. 7 mos. 21 ds. or — min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE
(State or country)

Md.

10 NAME OF FATHER

Robert Hale

11 BIRTHPLACE OF FATHER
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Margaret Miller

13 BIRTHPLACE OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Carr

(Address)

324 N. Pulaski St

15 JUL 31 1915

HARRY O. ANDREWS,

Filed

191

Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 29, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 31, 1915, to, July 29, 1915.

that I saw her alive on July 28, 1915,

and that death occurred, on the date stated above, at 1:20 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma - pelvis + abdominal organs

Probably 2 yrs. — mos. — ds.

Contributory
(SECONDARY)

(Duration) — yrs. — mos. — ds.

(Signed) M. E. Carr and Son M. D.

July 29, 1915 (Address) 626 N. Gilman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore

July 31, 1915

20 UNDERTAKER

ADDRESS

Chas. E. French 822 Madison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *2120 E. Pratt* St. *1* WARD)

FULL NAME *Mary Walton Edwards (Edwards)*

(Residence in Baltimore: No. *2120 E. Pratt* St.; yrs. *38* mos. *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*

4-COLOR OR RACE, *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)

6-DATE OF BIRTH, *October 30, 1852*

(Month)

(Day)

(Year)

7-AGE, *62 yrs. 8 mos. 29 ds.*

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer), *At home*

9-BIRTHPLACE, (State or Country), *Delaware*

10-NAME OF FATHER, *Alexander S. Davis*

11-BIRTHPLACE OF FATHER (State or Country), *Delaware*

12-MAIDEN NAME OF MOTHER, *Mary Walton*

13-BIRTHPLACE OF MOTHER (State or Country), *Del*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William F. Edwards*

(Address) *2120 E. Pratt St.*

15-

JUL 31 1915

HARRY O. ANDREWS,

1915 *Funeral Permit Clerk* *Registrar*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 29, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *David W. Jones* M. D. (Coroner)

July 29, 1915 (Address) *5116 Edmond St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Barretts Chapel*

DATE OF BURIAL, *Aug. 2, 1915*

20-UNDERTAKER, *Wm. C. Black*

ADDRESS *927 N. Bond St.*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REGISTERED NO. C 109

20-UNDEBTAKER ADDRESS
 221 N Broadway

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87091

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87091

PLACE OF DEATH
CITY OF BALTIMORE (No. *341 N. Stucker* ST. *19* WARD)
FULL NAME *Mr Charles Schultz*
(Residence in Baltimore: No. *341 N. Stucker* St. *6* yrs. *6* mos. *5* ds.)
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word)
6 DATE OF BIRTH *Jan 24, 1854*
(Month) (Day) (Year)
7 AGE *61* yrs. *6* mos. *5* ds. or less than 1 day, hrs. or min.?
8 OCCUPATION
(a) Trade, profession, or particular kind of work *Super Store*
(b) General nature of industry, business, or establishment in which employed (or employer) *Super*
9 BIRTHPLACE
(State or country) *City*
10 NAME OF FATHER *John Schultz*
11 BIRTHPLACE OF FATHER *Germany*
(State or country)
12 MAIDEN NAME OF MOTHER *Margaret Book*
13 BIRTHPLACE OF MOTHER *Germany*
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 JUL 31 1915

DANIEL O. ANDREWS,
Burial Permit Clerk,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 29, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from *April 15, 1915* to *July 29, 1915*.
that I saw him alive on *July 28, 1915*.
and that death occurred, on the date stated above, at *8:50 a.m.*
The CAUSE OF DEATH* was as follows:

Myocarditis
Scleremia

Contributory (SECONDARY) *Myocarditis*
(Duration) *2* yrs. *0* mos. *0* ds.

(Signed) *John A. Carey* M. D.
July 30, 1915 (Address) *101 N. Carey St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *0* yrs. *0* mos. *0* ds. In the State *0* yrs. *0* mos. *0* ds.
Where was disease contracted,
If not at place of death?
Former or
Usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gordon Park

Aug 1, 1915

20. UNDERTAKER

ADDRESS

Mr. White & Son 2503 Calmerton
are

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87092		HEALTH DEPARTMENT—CITY OF BALTIMORE		C87092	
PLACE OF DEATH		CERTIFICATE OF DEATH		REGISTERED NO. C	
CITY OF BALTIMORE (No. <u>2510 Dalem</u>)		ST. <u>15</u> WARD)		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
2-FULL NAME <u>Christian Wild</u>		(Residence in Baltimore: No. <u>2510 Dalem</u>)		St. <u>31</u> yrs. mos. ds.)	
PERSONAL AND STATISTICAL PARTICULARS					
3-SEX <u>Male</u>	4-COLOR OR RACE <u>White</u>	5-SINGLE, MARRIED, WIDOWED OR DIVORCED <u>married</u> (Write the word)			
6-DATE OF BIRTH <u>August 17, 1845</u> (Month) (Day) (Year)					
7-AGE <u>69</u> yrs. <u>11</u> mos. <u>11</u> ds. If LESS than 1 day, hrs. or min.?					
8-OCCUPATION (a) Trade, profession, or particular kind of work <u>Gardener</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9-BIRTHPLACE (State or country) <u>Germany</u>					
PARENTS	10-NAME OF FATHER <u>Gottfried Wild</u>				
	11-BIRTHPLACE OF FATHER (State or country) <u>Ger.</u>				
	12-MAIDEN NAME OF MOTHER <u>Not known</u>				
	13-BIRTHPLACE OF MOTHER (State or country) <u>Ger.</u>				
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Wild</u> (Address) <u>2510 Dalem St.</u>					
JUL 31 1915 Filed		HARRY O. ANDREWS, Serial Permit Clerk REGISTRAR			
MEDICAL CERTIFICATE OF DEATH					
16-DATE OF DEATH <u>July 28th, 1915</u> (Month) (Day) (Year)					
17- I HEREBY CERTIFY, That I attended deceased from <u>Aug 3, 1915</u> , to <u>July 28, 1915</u> , that I saw him alive on <u>July 28, 1915</u> , and that death occurred, on the date stated above, at <u>7:54 P.M.</u> The CAUSE OF DEATH* was as follows: <u>General weakness</u> <u>(Artero-sclerotic)</u> (Duration) <u>2</u> yrs. mos. ds. Contributory <u>grad. weakening</u> (SECONDARY) <u>no history of disease</u> (Duration) yrs. mos. ds. (Signed) <u>Ed. Smith</u> M. D. <u>July 29, 1915</u> (Address) <u>No 577 North Ave.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence					
19-PLACE OF BURIAL OR REMOVAL <u>Baltimore Cemetery</u>				DATE OF BURIAL <u>July 31st, 1915</u>	
20-UNDERTAKER <u>Frederick Cassaku Sons</u>				ADDRESS <u>Fullerton Md.</u>	

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1103 Latopree* ST.; *23* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Paul S. Koch (Koch)*(Residence in Baltimore: No. *1103 Latopree* St.; *—* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)6-DATE OF BIRTH, *Unknown*, 1.....

(Month)

(Day)

(Year)

7-AGE *37*

yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *Julian A Koch*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Agusta Keen*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Mary Koch*(Address) *1103 Latopree St.*

15-

JUL 31 1915

HARRY O. ANDREWS,

Burial Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 30, 1915*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *July 29* 1915, to *July 30* 1915, that I saw him alive on *July 30* 1915, and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Peritonitis*

(Duration) yrs. mos. ds.

(Signed) *R. P. Andrews* M. D.*July 30, 1915* (Address) *1644 E. Avenue*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cedar Hill Cyn*DATE OF BURIAL, *July 31, 1915*20-UNDERTAKER *Wm Cook*ADDRESS *5026 North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

915 E Preston

ST.:

WARD)

REGISTERED NO. C

2-FULL NAME

Mabel F. Degenhardt

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

915 E Preston

St.; 34 yrs., 1 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

June

16

1881

(Month)

(Day)

(Year)

7-AGE,

34

yrs.

1

mos.

14

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Balls Blad

PARENTS.

10-NAME OF FATHER,

James Derby

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER (State or Country),

not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mabel Degenhardt Jr.

(Address)

915 E Preston

15-

JUL 31 1915

1915

HARRY O. ANDREWS,

Burial Permit Officer Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

(Month)

30, 1915

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 26 1915, to July 30 1915, that I saw him alive on July 29 1915, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 6 mos.

CONTRIBUTORY (Secondary)

(Duration) 1 yr. 1 mos. 14 ds.

(Signed) Blumer Weiss M. D.

7/30, 1915 (Address) 914 E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery Aug. 1, 1915

20-UNDERTAKER

ADDRESS

Henry Knoch & Son 1301 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1229 E Chase* ST.; *10* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary E Ehm*(Residence in Baltimore: No. *1229 E Chase* St.; *50* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

*MARRIED,**WIDOWED,**OR DIVORCED,**(Write the word.)**Widow*

6-DATE OF BIRTH,

not known

(Month)

(Day)

(Year)

7-AGE,

*76**—* yrs., *—* mos., *—* ds.

If LESS than 1 day,

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife at home

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

M. Fäth

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER (State or Country),

not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Amelia Ehm*(Address) *1229 E Chase St*

15-

Filed *JUL 31 1915*

HARRY O. ANDREWS,

Baptist Paralt. Clery Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July

(Month)

30, 1915

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 26, 1915, to July 30, 1915,*that I saw her alive on *July 29, 1915,*and that death occurred, on the date stated above, at *9-9 m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(X-ray + Necropsy) (Duration) *—* yrs., *4* mos., *—* ds.

CONTRIBUTORY (Secondary)

(Duration) *—* yrs., *—* mos., *—* ds.(Signed) *John S. Farby* M. D.*7/30, 1915* (Address) *1223 N. Caroline St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs., *—* mos., *—* ds. In the State *—* yrs., *—* mos., *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Cemetery

DATE OF BURIAL,

Aug 2nd, 1915

20-UNDERTAKER

Henry Brock Shum

ADDRESS

1301 E Engle St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *Johns Hopkins Hosp* ST. *24* WARD)
FULL NAME *Maggie Beyer*
(Residence in Baltimore: No. *1741 Landing Ave* St. *Life* mos. *ds.*
2219 Winterling Court)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*
(Write the word.)
DATE OF BIRTH *Sept 13, 1903*
(Month) (Day) (Year)
AGE *11* yrs. *10* mos. *16* ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

child

9-BIRTHPLACE, (State or Country),

md (city)

10-NAME OF FATHER,

John Beyer

11-BIRTHPLACE OF FATHER (State or Country),

md

12-MAIDEN NAME OF MOTHER

Mary Schroll

13-BIRTHPLACE OF MOTHER (State or Country),

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Beyer

(Address)

1741 Landing Ave

15-

JUL 31 1915

HARRY O. ANDREWS,

Filed

101

Marital Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 29, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest.
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry.) And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

(Accident.) Meningitis

CONTRIBUTORY (Secondary)

Refle. Chop wound in

head (Duration) yrs. mos. ds.

(Signed) *Elijah S. Russell* M. D.

July 30, 1915 (Address) *428 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the *Life* State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

2219 Winterling Ct

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Sam'l Beart

July 31, 1915

20-UNDERTAKER

ADDRESS

Wm. J. Turner *1442 Brady*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2924 Elliott*ST.: *1*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Bridget Pawley*(Residence in Baltimore: No. *2924 Elliott*St.: *2* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow*
(Write the word.)

6-DATE OF BIRTH, *Not Known*, 1.....
(Month) (Day) (Year)

7-AGE, *51* yrs., mos. ds. It LESS than 1 day.
.....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *House Work*
(b) General nature of industry, business, or establishment in which employed (or employer), *at home*

9-BIRTHPLACE, (State or Country), *Ireland*

10-NAME OF FATHER, *James Pinnery*

11-BIRTHPLACE OF FATHER (State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER, *Mary Doyle*

13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Pawley*

(Address) *2924 Elliott St.*

15- *JUL 31 1915* HARRY O. ANDREWS,

Barial Pormie Olark Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 30*, 191*5*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 26* 191*5*, to *July 30* 191*5*, that I saw h *er* alive on *July 30* 191*5*, and that death occurred, on the date stated above, at *8 P.*m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY *Myocarditis*
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *W. J. McAvoy* M. D.

July 31, 191*5*. (Address) *839 S. Ellwood*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral

Aug. 2, 191*5*.

20-UNDERTAKER

ADDRESS

Stephen J. Fialkowski 1019 S. Kenwood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.:

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; *2* mos. *29* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

1915

HARRY O. ANDREWS,

Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....

(Inquest, au-

topsy or inquiry) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Sublethral Indigestion

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

(Coroner.)

M. D.

July 30, 1915 (Address) *3116 Osbourne St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *87099*)ST.: *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1634 Mulliken St.*)

St.: — yrs., — mo., — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15

JUL 31 1915

Filed..... 191..

HARRY O. ANDREWS,

Baltimore Form 14-0101
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on July 27 1915, and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) *Edna A. Dylott* M. D.
July 29 1915 (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mo. ... da. In the State... yrs. ... mo. ... da.

Where was disease contracted, if not at place of death? *1634 Mulliken St.*Former or usual residence *1634 Mulliken St.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *425, S. Chester* ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Stanislau Kikola*(Residence in Baltimore: No. *425, S. Chester* St.;

1 yrs., 3 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) *Single*

6-DATE OF BIRTH,

*Apr.**12,**1914*

(Month)

(Day)

(Year)

7-AGE,

*1**3**12*

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Nurse**Infant*

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Wladyslaw Kikola

11-BIRTHPLACE OF FATHER (State or Country),

S. River, N.J.

12-MAIDEN NAME OF MOTHER

Ellie Wojciechowski

13-BIRTHPLACE OF MOTHER (State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *W. Kikola*(Address) *425, S. Chester*

15-

JUL 31 1915

Filed

191

HARRY O. ANDREWS,

Bureau of Health Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 30, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *July 29, 1915* to *July 30, 1915*, that I saw him alive on *July 30, 1915*, and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

Diphtheria complicated with scarlet fever

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Infection
(Duration) yrs. mos. ds.(Signed) *E. J. Brown* M. D.*July 31, 1915* (Address) *2400 E. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

July 31, 1915

20-UNDERTAKER

William Halliwell

ADDRESS

1618 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *111 N. Vincent* ST. *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *111 N. Vincent* St. *50* yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*Leol*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widow*

6-DATE OF BIRTH,

— 1845 — 1
(Month) (Day) (Year)

7-AGE,

70 (not known.) It LESS than 1 day. hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housework at home*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Howard Co Md

10-NAME OF FATHER,

not known

11-BIRTHPLACE OF FATHER (State or Country),

not known

12-MAIDEN NAME OF MOTHER

Harriet Robinson

13-BIRTHPLACE OF MOTHER (State or Country),

Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Margaret Mathews*(Address) *111 N. Vincent St*

15-

JUL 31 1915

HARRY O. ANDREWS,

Filed *1915* *Partial Permit Clerk* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July — 29, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 20th* 1915, to *July 29* 1915, that I saw her alive on *July 29* 1915, and that death occurred, on the date stated above, at *9 P. m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) — yrs. — mos. *9* ds.

CONTRIBUTORY (Secondary)

(Signed) *F. B. Link* M. D.
July 30th 1915. (Address) *1313 W. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Andrew

DATE OF BURIAL,

July 31 1915

20-UNDERTAKER

Willie Brown

ADDRESS

316 N. Kent St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *No 1 West 10 Stend* ST. *23* WARD) REGISTERED No. C
2-FULL NAME *Peter H. Roth*
(Residence in Baltimore: No. *No 1 West 10 Stend* St. *45* yrs., *1* mos., *1* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widower*
6-DATE OF BIRTH. *Nov 7*, 18*34*
(Month) (Day) (Year)
7-AGE. *80* yrs., *7* mos., *21* ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Sailor*
(b) General nature of industry, business, or establishment in which employed (or employer). *mens*

9-BIRTHPLACE, (State or Country), *Germany*
10-NAME OF FATHER, *Momitable*
11-BIRTHPLACE OF FATHER (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER, *Momitable*
13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Helen Haehling*

(Address) *No 1 West 10 Stend*

15- JUL 31 1915

Filed..... 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 28*, 191*5*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *July 1* 191*5*, to *July 28* 191*5*, that I saw him alive on *July 25* 191*5*, and that death occurred, on the date stated above, at *9 P* m.

The CAUSE OF DEATH* was as follows:

Infirmities of old age
(Duration) yrs. mos. *28* ds.

CONTRIBUTORY (Secondary) *infirmities*
(Duration) yrs. mos. *14* ds.

(Signed) *R. P. Campbell* M. D.

July 30, 191*5* (Address) *1644 Hancock St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

London Park *Aug 1st*, 191*5*

20-UNDERTAKER ADDRESS

William Cook *502 E. North Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2811 Elliott* ST.;

REGISTERED NO. C

FULL NAME *Henry Schoener*(Residence in Baltimore: No. *2811 Elliott* St.;

2 yrs., 6 mos. 15 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Jan 16, 1913
(Month) (Day) (Year)

7-AGE,

2 yrs., *6* mos., *15* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Child*9-BIRTHPLACE,
(State or Country),*Balto. Md.*

10-NAME OF FATHER,

*Henry Schoener*11-BIRTHPLACE OF FATHER
(State or Country),*Balto. Md.*

12-MAIDEN NAME OF MOTHER

*Anna Malone*13-BIRTHPLACE OF MOTHER
(State or Country),*Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Schoener*(Address) *2811 Elliott St.*

JUL 31 1915

Filed

191

HARRY O. ANDREWS,

Baptist Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 31, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 23* 1915, to *July 31* 1915, that I saw him alive on *July 31* 1915, and that death occurred, on the date stated above, at *3 a* m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever(Duration) ... yrs. ... mos. *7* ds.CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *A. B. Tilton* M. D.*July 31*, 1915. (Address) *3035 O'Donnell St.*

(State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Cross

DATE OF BURIAL,

Aug 1, 1915.

20-UNDERTAKER

Lilly Zeller

ADDRESS

408 S. Carey St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1417 Acker

ST. 24 WARD)

2-FULL NAME

Howard Francis Miles

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1417 Acker St.

St. yrs. 5 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

Feb 13, 1915

7-AGE

5 yrs. 18 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

not any

9-BIRTHPLACE (State or country)

Maryland (City)

10-NAME OF FATHER

Oliver Miles

11-BIRTHPLACE OF FATHER (State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Ada E. Hubbard

13-BIRTHPLACE OF MOTHER (State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Oliver Miles

(Address)

1417 Acker St

JUL 31 1915

Filed

HARRY O. ANDREWS,
Berial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 31, 1915

17-I HEREBY CERTIFY, That I attended deceased from

July 20, 1915, to July 31, 1915

that I saw him alive on July 30, 1915

and that death occurred, on the date stated above, at 11:30 AM.

The CAUSE OF DEATH* was as follows:

Toxemia

Contributory (SECONDARY)

Ileo-Colitis

(Signed)

L. H. Rixton

July 31, 1915 (Address) 801 E. Cross St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

bedon Hill

DATE OF BURIAL

Aug 1, 1915

20-UNDERTAKER

J. Frew M. M. M. M.

ADDRESS

39 E. F. F. F.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2051 E. Monument* ST.; *7* WARD)2-FULL NAME *John F. Tauber*(Residence in Baltimore: No. *2051 E. Monument* St.; *45* yrs., *4* mos., *19* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widower

6-DATE OF BIRTH

Mar 10th, 1853
(Month) (Day) (Year)

7-AGE

62 yrs., 4 mos., 19 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Baker*

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

John Tauber

11-BIRTHPLACE OF FATHER,

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER,

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Elizabeth Ebert*(Address) *2051 E. Monument*

15-

JUL 31 1915

Filed

191

*ROBERT O. ANDRINS**Registrar*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 29th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1, 1915*, to *July 29, 1915*, that I saw him alive on *July 28, 1915*, and that death occurred, on the date stated above, at *9 P.* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) yrs. mos. *29* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Walter S. D.**July 30, 1915* (Address) *6 S. Bond*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mathews Cem. Aug. 1, 1915

20-UNDERTAKER

ADDRESS *2016**Philip Herwig Orleans*

CHANGE OF DEATH IN PRINT TERMS, IS THAT IT MAY BE PROPERTY CLASSIFIED. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *247* *Lo Robinson* St. *1* WARD)

FULL NAME *Geo Hermann English*

Residence in Baltimore: No. *247* *Lo Robinson* St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

6 DATE OF BIRTH *July 31, 1915* (Month) (Day) (Year)

7 AGE yrs. mos. ds. or less than 1 day 16 hrs. *16 1/2*

8 OCCUPATION (a) Trade, profession, or particular kind of work *None* (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Baltimore City*

10 NAME OF FATHER *Mr R English*

11 BIRTHPLACE OF FATHER (State or country) *Maryland Co*

12 MAIDEN NAME OF MOTHER *Ada B Hermann*

13 BIRTHPLACE OF MOTHER (State or country) *Maryland Co*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mr R English*

(Address) *247 Lo Robinson*

15 JUL 31 1915 HARRY O. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 31, 1915* (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 30, 1915*, to *July 31, 1915*, that I saw him alive on *July 30, 1915*, and that death occurred, on the date stated above, at *5 9* m. The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) yrs. mos. ds. *16 1/2*

Contributory (SECONDARY) *None*

(Signed) *W. C. Baker* M. D. *July 31, 1915* (Address) *330 E. North St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mardella Spring Md Aug 1, 1915

20 UNDERTAKER ADDRESS *Philip Herwig Orleans*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

824 Lennon

ST. 18 WARD

2-FULL NAME

Calma Chew

(Residence in Baltimore: No.

824 Lennon

St. 0 yrs. 10 mos. 5 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

colored

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

infant

6-DATE OF BIRTH

September 25, 1914
(Month) (Day) (Year)

7-AGE

no yrs. 10 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE

(State or country)

Balto, Md.

10-NAME OF FATHER

Luo Chew

11-BIRTHPLACE OF FATHER
(State or country)

Balto, Md.

12-MAIDEN NAME OF MOTHER

Lucy Wright

13-BIRTHPLACE OF MOTHER
(State or country)

Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lucy Chew.

(Address)

824 Lennon St.

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

July 30, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from

July 14, 1915, to July 30, 1915, that I saw her alive on July 26, 1915, and that death occurred on the date stated above, at 9:00 a. m.

The CAUSE OF DEATH* was as follows:

ileo-colitis

(Duration) yrs. mos. 17 ds.

Contributory none
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Chester Pelland, M. D.

July 31, 1915 (Address) 2532 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Auburn Cem

August 1, 1915

20-UNDERTAKER

Wm H Hooper

ADDRESS

600 Littleton St

B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 1 - 1915

HARRY O. ANDREWS,

Burial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *630 Hanover*ST.: *22* WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Ida Hack*(Residence in Baltimore: No. *630 Hanover*St.: *—* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colord.

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

single

6-DATE OF BIRTH,

March 20, 1896
(Month) (Day) (Year)

7-AGE,

19 yrs. *4* mos. *10* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Henry Hack*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ida Hack*(Address) *630 Hanover St.*

15-AUG 1 - 1915

HARRY O. ANDREWS,

Filed..... 191.....

BRIEF POST-MORTEM
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 30, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 16, 1915, to July 30, 1915,*that I saw her alive on *July 30, 1915,*and that death occurred, on the date stated above, at *7 P. m.*

The CAUSE OF DEATH* was as follows:

*Primary - Lobar Pneumonia**Immediate - Exhaustion*(Duration)..... yrs. mos. ds. *15*CONTRIBUTORY
(Secondary)(Duration)..... yrs. mos. ds. *15*(Signed) *J. L. Brown*

M. D.

7/31/15, 1915 (Address) *506 Hanover St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Ct

DATE OF BURIAL,

Aug. 15, 1915

20-UNDERTAKER

J. L. Brown & Son 102 W. Mount St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)9-BIRTHPLACE
(State or country)

PARENTS

10-NAME OF
FATHER11-BIRTHPLACE
OF FATHER
(State or country)12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on
and that death occurred, on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of the Kidney

(Duration) yrs. 3 mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. 1 mos. ds.

(Signed),

July 31st, 1915 [Address] John Hopkins Hospital

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. 3 mos. ds. In the 5 yrs. 3 mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence Gladys West. Virginia

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

18-

AUG 1 - 1915

HARRY O. ANDREWS,

Bureau of Health Officer
REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *603 N. Bruce* ST.; *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *C. LeRoy King*(Residence in Baltimore: No. *603 N. Bruce* St.; *—* yrs., *1* mos. *17* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

June 12, 1915
(Month) (Day) (Year)

7-AGE,

1 mos. 17 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, business, or establishment in which

employed (or employer).....

None

9-BIRTHPLACE,

(State or Country),

Balto.

10-NAME OF FATHER,

Frank King

11-BIRTHPLACE

OF FATHER
(State or Country),*Balto.*

12-MAIDEN NAME

OF MOTHER

Florence Stevens

13-BIRTHPLACE

OF MOTHER
(State or Country),*Balto.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Frank King*(Address) *603 N. Bruce*

15-

Filed

AUG 1 - 1915

191

HARRY O. ANDREWS,

MARTIN PERMIT, 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 28, 1915, to Aug 1, 1915,*that I saw him live on *July 31, 1915,*and that death occurred, on the date stated above, at *5:00 p.m.*

The CAUSE OF DEATH* was as follows:

Enteric Colic

.....

..... (Duration) *4* yrs. *4* mos. *4* ds.

CONTRIBUTORY

(Secondary)

..... (Duration) *2* yrs. *2* mos. *2* ds.Signed) *J. C. Targuison* M. D......, 1915 (Address) *1230 p. Charles St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*London Park**Aug 2, 1915*

20-UNDERTAKER

ADDRESS

*William Cook**302 E. N. Ave*

Specimen of certificate in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *323 S. Chapel* ST.; *2* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Elizabeth L. Monroe(Residence in Baltimore: No. *323 S. Chapel St.* St.;yrs., *3* mos. *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

April 7, 1915
(Month) (Day) (Year)

7-AGE,

3 yrs. 3 mos. 24 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore City.

PARENTS.

10-NAME OF FATHER,

William D. Monroe

11-BIRTHPLACE OF FATHER (State or Country),

Balto City.

12-MAIDEN NAME OF MOTHER

Barbara Boehm

13-BIRTHPLACE OF MOTHER (State or Country),

Balto City.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William D. Monroe*(Address) *323 S. Chapel St.*

15-

*AUG 1 - 1915 HARRY O. ANDREWS,*Filed..... *Marial Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 31, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 30th* 1915, to *July 31st* 1915, that I saw her alive on *July 30th* 1915, and that death occurred, on the date stated above, at *1:30 p.m.*

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis(Duration).....yrs.....mos.....ds. *2 ds.*

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds. *Same*(Signed) *Jacob L. Winters, M. D.**8-11-1915* (Address) *30 S. B. Way*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Am.

DATE OF BURIAL,

July 3, 1915

20-UNDERTAKER

Lilly & Ziehl

ADDRESS

403 S. W. 1st St.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C.

CITY OF BALTIMORE: (No.)

ST.

WARD) 7

2-FULL NAME

William Hohbein

(Residence in Baltimore: No.)

2522 E. Madison

St.

40

yrs.

mos.

da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR-DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

Dec. 30, 1834

(Month)

(Day)

(Year)

7-AGE

77

yrs.

7

mos.

1

ds.

or

min.?

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Germany

10-NAME OF FATHER

Edmar Hohbein

11-BIRTHPLACE OF FATHER (State or country)

Germany

12-MAIDEN NAME OF MOTHER

Elizabeth Hohbein

13-BIRTHPLACE OF MOTHER (State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

AUG 1 - 1915

Filed

191

HARRY O. ANDREWS,

Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 31

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

No record

191

to,

191

that I saw him alive on July 25, 1915

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Fracture of neck of thigh
about 1730 (accident)

Contributory (SECONDARY)

Robbery & assault

(Signed)

F. H. W. Jones

M. D.

July 2, 1915

[Address]

1133 Valley n

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 1 yrs. 4 mos. In the 40 yrs. mos. ds.

Where was disease contracted, Little Sisters of the Poor

If not at place of death? Little Sisters of the Poor

Former or usual residence Little Sisters of the Poor

19-PLACE OF BURIAL OR REMOVAL

St. German W. E. V. Church

DATE OF BURIAL

Aug 2, 1915

20-UNDERTAKER

Frank Brockson

ADDRESS

1904 Hubbard st

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87113

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87113

CERTIFICATE OF DEATH

x 45

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7* WARD)

2-FULL NAME *Madison Mason*

(If death occurred in a hospital or institution, give its NAME instead of street and number and (N out No. 18.)

(Residence in Baltimore: No. *Johns Hopkins Hospital* St.; yrs. mos. *26* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

March 27th

1859

7-AGE

56 yrs. *4* mos. *4* ds. or min.?

If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Clergyman

9-BIRTHPLACE

(State or country)

Ohio

PARENTS

10-NAME OF FATHER

Alfred Mason

11-BIRTHPLACE OF FATHER (State or country)

Mississippi

12-MAIDEN NAME OF MOTHER

Julia Phelan

13-BIRTHPLACE OF MOTHER (State or country)

La ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

P. Rozzel
Johns Hopkins Hospital

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 31st

1915

I HEREBY CERTIFY, That I attended deceased from *July 31st*, 1915, to *July 31st*, 1915,

that I saw him alive on *July 31st*, 1915, and that death occurred, on the date stated above, at *4¹⁵* m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Uraemia of 17 months
about 4 yrs. chronic
Contributory (SECONDARY) *Uraemia*

(Signed) *William H. Frost* M. D.
7/31/15 1915 [Address] *J. H. Hospital*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *26* ds. In the State yrs. mos. *26* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *2231 Pt. James Ave. Cincinnati Ohio*

19-PLACE OF BURIAL OR REMOVAL

Cincinnati, Ohio

DATE OF BURIAL

Aug. 3, 1915

20-UNDERTAKER

John H. Tordin

ADDRESS

142 W. Hill St

AUG 1 - 1915

Filed 191

HARRY O. ARLE

Marial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 N. Laburnum ST. 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary F. Gallagher(Residence in Baltimore: No. 602 N. Laburnum ave St.: yrs. 9 mos. 21 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Single

6-DATE OF BIRTH.

Oct 4, 1914
(Month) (Day) (Year)

7-AGE.

yrs. 9 mos. 26 da.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),Balto. Md.

10-NAME OF FATHER,

John Gallagher11-BIRTHPLACE OF FATHER
(State or Country),Balto. Md.

12-MAIDEN NAME OF MOTHER

Catherine Garry13-BIRTHPLACE OF MOTHER
(State or Country),Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Gallagher(Address) 602 N. Laburnum

15-

AUG 1 - 1915HARRY O. ANDREWS,Filed..... 1915 Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 31, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 31 1915, to July 31 1915,that I saw her alive on July 31 1915,and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chorea Infantum(Duration).....yrs.....mos..2..da.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....da.

(Signed) T. A. Healer M. D.July 24, 1915. (Address) 2600 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

New Cathedral

DATE OF BURIAL

Aug 2nd 1915

20-UNDERTAKER

John A. Mowbray & Co.

ADDRESS

Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2014 Bank St* ST.; *2* WARD)

REGISTERED NO. C

2. FULL NAME

(Residence in Baltimore: No. *2014 Bank St* St.; *2* yrs. *2* mo. *2* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*Widowed*

6. DATE OF BIRTH.

June, 18*23*
(Month) (Day) (Year)

7. AGE

92 yrs. *1* mo. *2* ds.
If LESS than 1 day, ... hrs. or ... min.?

8. OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9. BIRTHPLACE,
(State or Country).*Somerset County, Md.*

PARENTS.

10. NAME OF FATHER.

*Don't know*11. BIRTHPLACE OF FATHER
(State or Country).*Don't know*

12. MAIDEN NAME OF MOTHER

*Don't know*13. BIRTHPLACE OF MOTHER
(State or Country).*Don't know*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John A. Moran
(Address) *Bank & Ann St.*

15.

AUG 1 - 1915
Filed..... 191*5*HARRY O. ANDREWS,
Baptist Minister, 101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH,

July 30th, 191*5*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *July 30*, 191*5*, to *July 30*, 191*5*, that I saw her alive on *July 30*, 191*5*, and that death occurred, on the date stated above, at *5:45* p. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea(Duration)..... yrs. *14* mos. *14* ds.CONTRIBUTORY
(Secondary)(Duration)..... yrs. *14* mos. *14* ds.(Signed) *John H. Reberger* M. D.*July 31*, 191*5*. (Address) *6709 Cheltenham*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. *14* mos. *14* ds. In the State..... yrs. *14* mos. *14* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*St. Bernard**Aug 2, 1915*

20. UNDERTAKER

ADDRESS

John A. Moran & Ann St.

Circles of DEATH in print form to that it may be properly classified. PART statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1104 Druid Hill Ave.* St.; *17* WARD)

FULL NAME

(Residence in Baltimore: No. *1104 Druid Hill Ave.* St.; *85* yrs., — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH.

Sept 1 (Month) *1* (Day) *1915* (Year)

7-AGE.

35 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Home*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Maryland (city)

10-NAME OF FATHER,

Louis Walker

11-BIRTHPLACE OF FATHER

(State or Country), *Ind*

12-MAIDEN NAME OF MOTHER

Ellen Lane

13-BIRTHPLACE OF MOTHER

(State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Barth Scott*(Address) *354 N. 3rd St.*

15-

AUG 1 - 1915

Filed

191

HARRY O. ANDREWS,

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 28, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 27, 1915* to *July 28, 1915*, that I saw him alive on *July 28, 1915*, and that death occurred, on the date stated above, at *11 p.m.*

The CAUSE OF DEATH* was as follows:

Cardiac Apoplexy

CONTRIBUTORY (Secondary)

(Duration) *15* yrs. — mos. — ds.

(Signed)

July 30, 1915 (Address) *354 N. 3rd St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Auburn

DATE OF BURIAL,

Aug. 1, 1915

20-UNDERTAKER

J. H. Scott

ADDRESS

1107 N. 3rd St.

Check of death in plain terms, so that it may be properly entered. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 Oxford—St.: 17 WARD)

REGISTERED No. C

2-FULL NAME William Bell

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 531 Oxford—St.; yrs., 5 mos. 3 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH.

Feb. 28—, 1915
(Month) (Day) (Year)

7-AGE.

5 yrs., 3 mos., 3 da.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

none

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

William Bell

11-BIRTHPLACE OF FATHER (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Lillian Parrott

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Bell(Address) 531 Oxford St.

15-

Filed AUG 1 - 1915

HARRY O. ANDREWS

Barral Per Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 31, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from July 29 1915, to July 31 1915, that I saw him alive on July 30—1915, and that death occurred, on the date stated above, at 4:45 p. m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(Duration)..... yrs..... mos..... da.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... da.

(Signed) Samuel A. Bain M. D.July 31, 1915. (Address) 937 Madison Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

Aug. 1, 1915

20-UNDERTAKER

John A. Bishop

ADDRESS

Druid Hill Ave

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2932 Mosher

ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Mary Elizabeth Duff

(Residence in Baltimore: No. English Concord Estate Balt. Co. Md.

yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

~~5-SINGLE~~

MARRIED, married

~~WIDOWED~~~~OR DIVORCED~~

(Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

1886 (Year)

7-AGE,

7 yrs. 7 mos. 27 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, House wife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), Phila. Pa.

PARENTS.

10-NAME OF FATHER,

Edward G. Cullen

11-BIRTHPLACE OF FATHER

(State or Country), Phila. Pa.

12-MAIDEN NAME OF MOTHER,

Catherine Cullen

13-BIRTHPLACE OF MOTHER

(State or Country), Phila. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Martha Cullen

(Address) 610 Hilton St.

15-

Filed

191

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 30

(Month)

(Day)

1915 (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 16 1915, to July 30 1915,

that I saw her alive on July 16 1915,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Purulent Pleurisy.

Chronica. Probably Tuberculosis.

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Pearce Kintzinger M. D.

July 30 1915. (Address) 1374 Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from Violent Causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Not Christ Church

Aug. 2, 1915

20-UNDERTAKER

ADDRESS

Joseph Syfer

1608 H. York

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. 13 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. 13 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH December 1, 1909 (Month) (Day) (Year)

7-AGE 5 yrs. 7 mos. 30 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 30, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July - 26, 1915, to July 30, 1915, that I saw him alive on July - 30, 1915, and that death occurred, on the date stated above, at 5:37 a.m. The CAUSE OF DEATH* was as follows:

Acute Osteo Myelitis of Left Tibia (Staphylococcus aureus) (Duration) — yrs. — mos. 7 ds.

Contributory (SECONDARY) Staphylococcus sepsis (Duration) — yrs. — mos. 4 ds. (Signed) M. B. Levin M. D. 7/30, 1915 (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. 5 ds. State 5 yrs. 7 mos. 30 ds. Where was disease contracted, 2931 Penn Ave. If not at place of death? Former or usual residence 2931 Penn Ave.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Address 2931 Penn Ave. 1915

15-AUG 1 - 1915

HARRY O. ANDREWS

Marial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1511 Beason* ST.; *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Catherine Bohle*Residence in Baltimore: No. *1511 Beason* St.; *70* yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Widow*

6-DATE OF BIRTH,

June 24, 1899
(Month) (Day) (Year)

7-AGE,

76 yrs., 1 mos., 5 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

*Housewife*9-BIRTHPLACE,
(State or Country),*Germany*

PARENTS.

10-NAME OF FATHER,

*Christian Deist*11-BIRTHPLACE OF FATHER
(State or Country),*Hoenelbach*

12-MAIDEN NAME OF MOTHER

*Gertrude Brown*13-BIRTHPLACE OF MOTHER
(State or Country),*Hoenelbach*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *E. Wassmann, Sister*(Address) *2206 McElderry St.*

15-

AUG 1 - 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 20, 1915, to July 29, 1915,*that I saw her alive on *July 29, 1915,*and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

Cholecystitis(Duration) *3 yrs., 3 mos., 5 ds.*CONTRIBUTORY
(Secondary)*Nephritis (acute)**parenchyma* (Duration) *2 yrs., 2 mos., 2 ds.*(Signed) *Stirrup, M. D.**7-29, 1915* (Address) *1270 North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Schuyler Cemetery, Aug. 1, 1915

20-UNDERTAKER

ADDRESS

W. H. Smith & Sons, North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 E Fayette ST.: 5 WARD)

REGISTERED NO. C

2-FULL NAME Nathan Goodman

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1007 E Fayette St. 27 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male4-COLOR OR RACE, White5-SINGLE, married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, Unknown

(Month)

(Day)

(Year)

7-AGE, 63 yrs., — mos., — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia10-NAME OF FATHER, Morris Goodman11-BIRTHPLACE OF FATHER (State or Country), Russia12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A M Mark(Address) 1614 E. 1st St15- AUG 1 - 1915

HARRY O. ANDREWS,

Marial Permit Clerk

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27th 1915, to July 31st 1915, that I saw him alive on July 30 1915, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH was as follows:

Central 7th Community

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration)..... yrs..... mos..... ds.

(Signed) James J. Gellert M. D.July 31, 1915 (Address) 108 E. 1st St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Hebrew HomeDATE OF BURIAL, Aug 1, 191520-UNDERTAKER, Johnson & CoADDRESS 1107 E

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87122

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87122

CERTIFICATE OF DEATH

1. PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1512 N. Mulberry

ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME

Mary Virginia Feldman

(Residence in Baltimore: No. 1512 N. Mulberry,

St. 19 yrs. \ mos. \ ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6. DATE OF BIRTH

August 5, 1875
(Month) (Day) (Year)

7. AGE

39 yrs. 11 mos. 26 ds. or 1 day, 11 hrs. 26 min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE (State or country)

Baltimore, Md.

10. NAME OF FATHER

William H. Roberts

PARENTS

11. BIRTHPLACE OF FATHER (State or country)

Baltimore, Md.

12. MAIDEN NAME OF MOTHER

Elizabeth Ann Donahoe

13. BIRTHPLACE OF MOTHER (State or country)

Baltimore, Md.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. Albert Feldman

(Address)

1512 N. Mulberry St.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 31, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 24, 1915, to July 31, 1915,

that I saw her alive on July 30, 1915,

and that death occurred, on the date stated above, at 1:15 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

Contributory (SECONDARY)

(Duration) yrs. \ mos. \ ds.

(Signed),

Albert S. Chambers, M. D.

(Address) 1012 N. Tappan St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. \ mos. \ ds. State yrs. \ mos. \ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn Cemetery

DATE OF BURIAL

Aug 2, 1915

20. UNDERTAKER

ARMSTRONG-DENNY CO.

ADDRESS

715 Light St

AUG 1 - 1915
Filed

HARRY O. ANDREWS,

Marial Permit Officer

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87123

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *3341 Greenmount av.*

ST.: *9* WARD)

REGISTERED NO. C

2-FULL NAME

Margaret A. S. Skinner

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *3341 Greenmount av.*

St.: *60* yrs. *6* mos. *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word)

6-DATE OF BIRTH

Oct.
(Month)

3
(Day)

1841
(Year)

7-AGE

73 yrs.

9 mos.

27 ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

New Jersey

10-NAME OF FATHER

Abraham A. Phillips

11-BIRTHPLACE OF FATHER

(State or country)

New Jersey

12-MAIDEN NAME OF MOTHER

Julia A. Shorey

13-BIRTHPLACE OF MOTHER

(State or country)

New Hampshire

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel A. S. Phillips

(Address)

3341 Greenmount av.

15

AUG 1 - 1915

191

HARRY O. ANDREWS,

Marial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July.
(Month)

30
(Day)

1915
(Year)

17-I HEREBY CERTIFY, That I attended deceased from

July. 15, 1915, to *July. 30*, 1915.

that I saw her alive on *July. 30*, 1915.

and that death occurred on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Contributory

(SECONDARY)

Exhaustion & Syncope with

(Signed)

July. 30

1915

(Address)

2801 York Road

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

CEDAR HILL Cemetery

DATE OF BURIAL

Aug 1, 1915

20-UNDERTAKER

ARMSTRONG-DENNY CO.

ADDRESS

715 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If deceased was under 18, state the exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 129 W. Hamburg St.)

2-FULL NAME

Michael Gritzuk

(Residence in Baltimore: No. 129 W. Hamburg)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., 3 mos., 11 da.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Married

6-DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7-AGE

30

YRS. MOS. DA.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Fireman B O R R Co

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE

(State or Country).

Russia

10-NAME OF FATHER

Wasiel Gritzuk

11-BIRTHPLACE OF FATHER

(State or Country).

Russia

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER

(State or Country).

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Steph Gritzuk

(Informant).

129 W. Hamburg St.

(Address).

15-

AUG

1915

FILED

HARRY O. ANDREWS, Registrar.

Serial 10111

ST. 23 WARD

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

July

29

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, au-

opsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Stroke

Taken sick at Riverside B O R R Co

(Duration) yrs. mos. da.

CONTRIBUTORY Found dead at home 6 P M.

(Secondary)

6 days later (Duration) yrs. mos. da.

(Signed) [Signature] M. D. (Coroner.)

July 31 1915 (Address) 517 Scott St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. da. State. yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Stanislaus Cemetery

Aug 9 1915

20-UNDERTAKER

ARMSTRONG-DENNY CO.

ADDRESS

715 Lgh St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *233 N. Bruce St.* ST. *19* WARD)

FULL NAME *Mary Elizabeth Ferguson*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *233 N. Bruce St.* St. *19* yrs. *6* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

Female *Black*

Single

6 DATE OF BIRTH

Jan *25*, 1915
(Month) (Day) (Year)

7 AGE

6 yrs. *5* mos. *5* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9 BIRTHPLACE (State or country)

Balto. City

10 NAME OF FATHER

William E. Ferguson

11 BIRTHPLACE OF FATHER (State or country)

Balto. City

12 MAIDEN NAME OF MOTHER

Louisa Leppard

13 BIRTHPLACE OF MOTHER (State or country)

Balto. City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. E. Ferguson
233 N. Bruce St.
(Address)

15

Filed

AUG 1

1915

HARRY O. ANDREWS

Serial Permit 0107

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July *30*, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 27, 1915, to *July 30*, 1915.

that I saw him alive on *July 30*, 1915.

and that death occurred, on the date stated above, at *6:30 P. m.*

The CAUSE OF DEATH* was as follows:

Dysentery

Contributory (SECONDARY)

Inanition (Duration) yrs. *14* mos. *14* ds.

(Signed) *W. E. Ferguson* M. D.

1915 (Address) *1905 E. Monument*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. *6* mos. *5* ds. In the State yrs. *6* mos. *5* ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount Auburn

Aug 1, 1915

20 UNDERTAKER

ADDRESS

Wilbert Brown

306 N. Mount

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 153 S. Robinson ST.; 1 WARD)

REGISTERED No. C

2-FULL NAME

August Theodore Keener

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 153 S. Robinson St.; 1 yrs., 6 mos., 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)6-DATE OF BIRTH. Jan 10/1914, 1 (Month) (Day) (Year)7-AGE. 1 yrs., 6 mos., 20 ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Colic
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, August Keener11-BIRTHPLACE OF FATHER (State or Country), Baltimore12-MAIDEN NAME OF MOTHER Mary E. Margaret13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Keener(Address) 153 S. Robinson15- AUG 1 - 1915 HARRY O. ANDREWS, 191 Marial Permit Clerk.
Filed..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 30/1915, 191...
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 19/15 191... July 30/15 191...
that I saw him alive on July 20/15 191...
and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis(Duration)..... yrs..... mos. 11 ds.CONTRIBUTORY Malnutrition
(Secondary)(Duration)..... yrs..... mos. 15 ds.(Signed) Frederick H. Hermann M.D.7/20/15 191... (Address) 2919 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Oakland Cemetery Aug 1, 1915

20-UNDERTAKER ADDRESS

Mellie Cook 502 E. North

Cause of death in plain text, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2518 Madison Ave. 13

WARD

2-FULL NAME

Bertha Rosenblatt

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

(Residence in Baltimore: No. 2518 Madison Ave. St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female white

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Jan 15 1864

(Month)

(Day)

(Year)

7-AGE

51 yrs. 6 mos. 16 ds. or min.?

If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9-BIRTHPLACE

(State or country)

Wash. D.C.

10-NAME OF FATHER

J. R. Kaufman

11-BIRTHPLACE OF FATHER

(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Sophia Kurl

13-BIRTHPLACE OF MOTHER

(State or country)

Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emanuel Rosenblatt

(Address)

2518 Madison Ave.

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

July 31 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from July 24, 1915, to July 31, 1915, that I saw her alive on July 30, 1915, and that death occurred, on the date stated above, at 7:25 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration)

yrs.

mos.

ds.

Contributory (SECONDARY)

Cacities

(Duration)

yrs.

mos.

ds.

(Signed)

J. E. Dumbarton M. D. July 31, 1915

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

In the

ds.

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

16-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Friendship Co. Aug 2, 1915

20-UNDERTAKER

ADDRESS

J. A. Harris Co 1611 Madison Ave

AUG 1 - 1915

HARRY O. ANDREWS,

Marial Permit Clerk

Filed: 191

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *208 S Bruce*ST. *19* WARD)

REGISTERED NO. C

2-FULL NAME

Bernadene Hild

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *208 S Bruce*

St.: — yrs., — mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, *Married*,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May 20, 1948
(Month) (Day) (Year)

7-AGE,

67 yrs. *3* mos. *11* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*Housewife*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Not known*13-BIRTHPLACE OF MOTHER
(State or Country),*Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*Frank H. Kuhl*(Address).....*206 S Bruce St.*

15-

AUG 1 - 1915

191

HARRY O. ANDREWS,

Marial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 31, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 1 1915, to *July 29* 1915,that I saw her alive on *July 29* 1915,and that death occurred, on the date stated above, at *230* m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis(Duration) *10* yrs. *6* mos. *11* ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *Walter A. Coe* M. D.*8.1*, 1915. (Address) *54 Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery Aug 3, 1915

20-UNDERTAKER

ADDRESS

Kuhl + Son 1729 N. Hall St

See Birth Certificate of
Julia Annie Wozanick,
Born Jan. 26th. 1915 B-38518
Parents Names Julia & Paul Wozanick,

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 S. Glover. ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Anna J. Gzinski Wozanick
(Residence in Baltimore: No. 802 S. Glover. St. yrs. 6 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, July 16, 1915 (Month) (Day) (Year)

7-AGE, 6 yrs. 6 mos. 15 ds. If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto. Md

10-NAME OF FATHER, Paul Gzinski

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Mary Wozanick

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Gzinski

(Address) 802 S. Glover St.

15-AUG 1 - 1915 HARRY O. ANDREWS, Registrar. Filed

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 29, 1915, to July 31, 1915, that I saw her alive on July 31, 1915, and that death occurred, on the date stated above, at 11 m. The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. J. Wozanick M. D. (Address) 165 B. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Anne's

DATE OF BURIAL, Aug 3, 1915

20-UNDERTAKER, M. J. Sadowski

ADDRESS, 705 S. Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *1938 Sherman Ave.*)

WARD

2-FULL NAME

Ellen Agnes Lerner

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1938 Sherman Ave.*)

St.; *8* yrs. *27* mos. *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Apr 3 1914*
(Month) (Day) (Year)

7-AGE *8 27* yrs. *27* mos. *27* ds. or *1* day, *27* hrs. *27* min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Balti Md.

PARENTS

10-NAME OF FATHER

John B Lerner

11-BIRTHPLACE OF FATHER
(State or country)

Balti Md.

12-MAIDEN NAME OF MOTHER

Ellen Connolly

13-BIRTHPLACE OF MOTHER
(State or country)

Balti Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Lerner

(Address)

1928 Sherman Ave

15-

ROBERT . KRAUTER

AUG 2 .. 1915

Serial Permit 0121

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 30 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 30 1915*, to *July 30 1915*, that I saw her alive on *July 30 1915*, and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross Cemetery

August 2 1915

20-UNDERTAKER

ADDRESS

George J. Ruth 2354 1/2 ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 213 Dry Alley ST. 4 WARD)

FULL NAME William Henry Lee

(Residence in Baltimore: No. 213 Dry Alley

34 yrs. 3 mos. 30 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

6 DATE OF BIRTH

April

1st

1881

(Month)

(Day)

(Year)

7 AGE

34

yrs.

3

mos.

30

ds.

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

porter

(b) General nature of industry, business, or establishment in which employed (or employer)

Jewelry store

9 BIRTHPLACE

(State or country)

Baltimore, Md.

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

Cassie Watson

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Foster

(Address)

531 N. Patterson Park Ave.

AUG 2 - 1915

ROBERT . KRAUTER

REGISTRAR

Filed

191

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

30

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

February 15, 1915, to July 30, 1915,

that I saw him alive on July 28, 1915,

and that death occurred, on the date stated above, at 11:10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

Clinical diagnosis

(Duration)

yrs.

7

mos.

—

ds.

Contributory (SECONDARY)

none

(Duration)

yrs.

—

mos.

—

ds.

(Signed)

Chester Poland

M. D.

July 30, 1915

(Address)

2532 Edmonson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

David Peters' Cem.

Aug 24, 1915

20 UNDERTAKER

ADDRESS

Robert A. Elliott, 586. East St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1807, N Caroline*ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Charles A. Scott(Residence in Baltimore: No. *1807, N Caroline*St.; *50* yrs., *0* mos. *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white

5-SINGLE,

*MARRIED,**WIDOWED,**OR DIVORCED,*

(Write the word.)

married

6-DATE OF BIRTH,

March 29, 1834
(Month) (Day) (Year)

7-AGE,

81 yrs., 4 mos., 2 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Bucklayer

(b) General nature of industry, business, or establishment in which employed (or employer).

*Employer*9-BIRTHPLACE,
(State or Country),*Baltimore Md*

10-NAME OF FATHER,

George Scott

11-BIRTHPLACE OF FATHER

(State or Country)

England

12-MAIDEN NAME OF MOTHER

Mary Heesh

13-BIRTHPLACE OF MOTHER

(State or Country),

Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Scott*(Address) *1807 N Caroline St*

15-AUG 2 - 1915

ROBERT KRAUTER

Filed..... 191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 31st, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *July 31st, 1915*that I saw him alive on *July 31st, 1915*and that death occurred, on the date stated above, at *11, 45 p.m.*

The CAUSE OF DEATH* was as follows:

Facility
(Duration) *unknown*18-CONTRIBUTORY
(Secondary)*Ed. Storer, M. D.*
(Signature) *August 1st, 1915* (Address) *1501 E. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Grand Ridge Cemetery**Aug. 2, 1915*

20-UNDERTAKER

ADDRESS

*John B. Spence**1325 N Caroline St*

Cause of death in plain terms, so that it may be properly classified. Enter statement of occupation in very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 Mulligan ST.; 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Orintha Crosby(Residence in Baltimore: No. 1231 Mulligan St.; 22 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH,

June 23rd, 1889
(Month) (Day) (Year)

7-AGE,

26 yrs., 1 mos., 3 ds.

IF LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework
her own work

9-BIRTHPLACE, (State or Country).

Somerset County Md

PARENTS.

10-NAME OF FATHER.

Joseph F. Waters

11-BIRTHPLACE OF FATHER (State or Country).

Somerset Co. Md

12-MAIDEN NAME OF MOTHER

Cassie Washington

13-BIRTHPLACE OF MOTHER (State or Country).

Somerset County Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr Cassie Waters
(Address) 15-3 East Street

15-

Filed

AUG 2 - 1915

ROBERT . KRAUTER

Serial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 30th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 26th 1915, to July 29th 1915, that I saw her alive on July 26 1915, and that death occurred, on the date stated above, at 6:50 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis
(Duration) 2 yrs., 2 mos., 3 ds.

CONTRIBUTORY (Secondary)

Cold
(Duration) 2 yrs., 2 mos., 3 ds.

(Signed)

M. E. Campbell M. D.July 31 1915. (Address) 1369 N. Carey St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Paul CemeteryAug 3, 1915

UNDERTAKER

ADDRESS

Robert A. Elliott1000 Rogers Ave

CAUSE OF DEATH is plain term, as that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87134

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87134

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1148 Low)
2-FULL NAME John Dennis
(Residence in Baltimore: No. 1148 Low)
REGISTERED NO. C. 5
ST. 5 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
St. 64 yrs. 5 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6-DATE OF BIRTH February 2nd, 1857
(Month) (Day) (Year)

7-AGE 64 yrs. 5 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Driver
(b) General nature of industry, business, or establishment in which employed (or employer) Lumber wagon

9-BIRTHPLACE (State or country) Virginia

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Ind

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Dennis
(Address) 1144 Low St

15-AUG 2 - 1915. ROBERT . KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 31st, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 14th, 1915, to July 31st, 1915, that I saw him alive on July 30th, 1915, and that death occurred, on the date stated above, at 8:30 a.m.
The CAUSE OF DEATH* was as follows: Acute

Myocarditis
Broncho pneumonia
(Duration) yrs. 3 mos. 16 ds.

Contributory (SECONDARY) Heart weakness
(Duration) yrs. 7 mos. 16 ds.

(Signed) Samuel J. Bick M. D.
Aug 1st, 1915 (Address) 1516 E. Pruiton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Garfield Cemetery DATE OF BURIAL Aug 2, 1915

20-UNDERTAKER Chas. B. Bailey ADDRESS Jefferson St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 624 N Dallas
2-FULL NAME *Beatrice Brooks*
(Residence in Baltimore: No. 624 N Dallas

REGISTERED No. C
St.: 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
St.: yrs., mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Female</i>	4-COLOR OR RACE, <i>Colored</i>	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. <i>Infant</i> (Write the word.)
6-DATE OF BIRTH, <i>July 11th, 1915</i> (Month) (Day) (Year)		
7-AGE, <i>20</i> yrs. <i>20</i> mos. <i>20</i> ds.		If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Infant</i> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), <i>Balt. Md</i>		
PARENTS.	10-NAME OF FATHER, <i>Wm P Brooks</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Md</i>	
	12-MAIDEN NAME OF MOTHER <i>Rosa Hagan</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Md</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm P Brooks*
(Address) *624 N Dallas St*

15- AUG 2 - 1915. ROBERT KRAUTER
Filed Serial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, *July 31st, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*, and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) *Elihu L Russell* M. D.
(Coroner.)
July 31, 1915 (Address) *1113 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mt Zion Cemetery

Aug 2, 1915

20-UNDERTAKER

Chas & Bailey

ADDRESS

Jefferson St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *4* WARD)

2-FULL NAME

Allen Berry

(Residence in Baltimore: No.

University Hospital St.;

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs., mos. *13* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

negro

5-SINGLE,

*MARRIED**WIDOWED,**OR DIVORCED,*

(Write the word.)

Married

6-DATE OF BIRTH,

Unknown, *1861*

(Month)

(Day)

(Year)

7-AGE,

54

If LESS than 1 day,

...hrs. or...min?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Farm Hand

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Albert Berry

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Allen Berry, Successor*(Address) *Bethesda, Md.*

AUG 2 - 1915

ROBERT . KRAUTER

Filed..... 191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 29, *1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 16 1915, to *July 29* 1915,that I saw him alive on *July 29* 1915,and that death occurred, on the date stated above, at *9 P.m.*

The CAUSE OF DEATH* was as follows:

*Uremia**Chronic*

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Intermittent Nephritis & Gastric enteritis

(Duration).....yrs.....mos.....ds.

(Signed) *Harry H. Allen, M.D.**July 29* 1915. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the *Life* State.....yrs.....mos.....ds.Where was disease contracted, if not at place of death? *Hughesville Md.*Former or usual residence *Hughesville Md.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Woodville, Craig, Md.**Aug 3, 1915*

20-UNDERTAKER

ADDRESS

*John R. Owens**1222 B...*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Morgan

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *15* WARD)2-FULL NAME *Angela Ford*(Residence in Baltimore: No. *1302 N Bruce St.* St.; *1* yrs. *14* mos. *14* ds.)REGISTERED NO. C. *104*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

*Col.*5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*Single*

6-DATE OF BIRTH

June 12, 1914

(Month)

(Day)

(Year)

7-AGE

1

yrs.

14

mos.

14

ds.

or

min.?

If LESS than
1 day, hrs.,
min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*None*

9-BIRTHPLACE

(State or country)

ind. Balto.

PARENTS

10-NAME OF FATHER

*James Ford*11-BIRTHPLACE OF FATHER
(State or country)*ind. Ches.*

12-MAIDEN NAME OF MOTHER

*Ella Hardy*13-BIRTHPLACE OF MOTHER
(State or country)*City Balto.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. Phelps

(Address)

Johns Hopkins Hosp.

15-

AUG 2 - 1915

ROBERT . KRAUTER,

Aerial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 1, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 31*, 1915, to, *Aug 1*, 1915, that I saw him alive on *Aug 1*, 1915, and that death occurred, on the date stated above, at *12:30* m.

The CAUSE OF DEATH* was as follows:

*Acute Intestinal Indigestion*Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

A. S. Rothholz M. D.
Aug 1, 1915 [Address] *Johns Hopkins Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence *1302 N Bruce St*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Johns Hopkins Hosp. *Aug 2, 1915*

20-UNDERTAKER

ADDRESS

Blair & Co. *1302 N Bruce St*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87133

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2512 Dacum

ST.

13

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Levi H Barnes Jr.

(Residence in Baltimore: No.

2512 Dacum

St.;

yrs.

mos.

3 mos.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

W

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Aug. 1

1915

(Month)

(Day)

(Year)

7-AGE,

If LESS than 1 day.

3 hrs. or... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Bald Mt.

PARENTS.

10-NAME OF FATHER,

Levi H Barnes

11-BIRTHPLACE OF FATHER

(State or Country),

Bald Co.

12-MAIDEN NAME OF MOTHER

Elizabeth Turnbull

13-BIRTHPLACE OF MOTHER

(State or Country),

Bald Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Levi H Barnes

(Address)

2512 Dacum St

15-

AUG 2 - 1915

ROBERT . . KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 1

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1 1915, to Aug. 4 1915, that I saw him alive on Aug. 1 1915, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia 7 mo fetus dead & respiration very weak

(Duration)

yrs.

mos.

3 hrs.

CONTRIBUTORY

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

E. E. Smith M. D.

Aug. 1 1915 (Address) 605 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Olivet Cemetery

DATE OF BURIAL,

Aug. 2 1915

20-UNDERTAKER

Christian Miller

ADDRESS

2536 Jefferson

CAUSE OF DEATH is plain text, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *20* WARD)2-FULL NAME *Becilla Harden*(Residence in Baltimore: No. *326 S. Furell St* St. *Furrow* yrs. mos. *13* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)*Single*

6-DATE OF BIRTH,

November 10th, 1909
(Month) (Day) (Year)

7-AGE,

*5 yrs. 9 mos. 21 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....*Child*

9-BIRTHPLACE,

(State or Country),

*Glechester Md.*10-NAME OF
FATHER,*Jesse Harden*11-BIRTHPLACE
OF FATHER
(State or Country),*Maryland*12-MAIDEN NAME
OF MOTHER*Anna Welsh*13-BIRTHPLACE
OF MOTHER
(State or Country),*Swilford Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Jesse Harden

(Address),

326 S. Furell St.

15-AUG 2 - 1915

ROBERT K. KRAUTER,

Filed..... 191.

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 1, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
July 18 1915, to *Aug 1* 1915,
that I saw her alive on *July 31* 1915,
and that death occurred, on the date stated above, at *1:30 A.m.*

The CAUSE OF DEATH* was as follows:

Pylemia(Duration)..... yrs. mos. *9* ds.CONTRIBUTORY.....
(Secondary)*Abscess of thigh*

(Duration)..... yrs. mos. ds.

(Signed)..... M. D.

8/1, 1915 (Address) *University City**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
IENTS, OR RECENT RESIDENTS).At place of death yrs. mos. *13* ds. In the State *Life* yrs. mos. ds.Where was disease contracted, *Baltimore 326 Furell St.*
If not at place of death?Former or usual residence *326 Furell St.*

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

Aug 3, 1915

20-UNDERTAKER

William Cook

ADDRESS

302 E North

CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

IF LESS than

1 day, hrs, min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

AUG 2 - 1915

ROBERT . KRAUTER,
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from July 26, 1915, to July 31, 1915,

that I saw him alive on July 31, 1915, and that death occurred, on the date stated above, at 8⁰⁰ p.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction.

Contributory (SECONDARY) Chronic pelvic inflammatory disease

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) J. H. H. M. D.

July 31, 1915. [Address] Johns Hopkins Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. 5 mos. 5 ds. In the State of Md.

Where was disease contracted, if not at place of death?

Former or usual residence 1321 Ashland Ave

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross

Aug 3, 1915

20-UNDERTAKER

ADDRESS

William Cook

502 E North Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087112 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2121 Boyd St. 20179)
2-FULL NAME Elizabeth Barber Wunder
(Residence in Baltimore: No. 2121 Boyd St.; yrs., 65¹ mos. ds.)
REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female
4-COLOR OR RACE white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow
6-DATE OF BIRTH, March 29th, 1874
(Month) (Day) (Year)
7-AGE, 41 yrs., mos. ds. If LESS than 1 day, ...hrs. or...min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), Germany
10-NAME OF FATHER, Conrad Huthner
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER, unknown
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mr. Geiker
(Address) 2121 Boyd St.

15-AUG 2 - 1915, ROBERT KRAUTER, Registrar
Filed....., 191... Permit No. 1121

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31st, 1915.
(Month) (Day) (Year)
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry. thereon and from the evidence obtained by said Inquest, autopsy or inquiry. And that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis (old age)
(Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Heat exhaustion...
(Duration) ... yrs. ... mos. ... ds.
(Signed) Moses H. Savary, M. D. (Coroner.)
Aug 2nd, 1915. (Address) 1729 Upshire Cir.
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).
At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence...
19-PLACE OF BURIAL OR REMOVAL, St. Alphonsus
DATE OF BURIAL, Aug 3 1915.
20-UNDERTAKER, William Cook
ADDRESS, 502 E. Nutt St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1314 Druid Hill Ave St. 17 WARD)2-FULL NAME Annie B White(Residence in Baltimore: No. 1314 Druid Hill Ave St. 17 WARD)St. 17 yrs. 30 mos. 4 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female Colored

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Married

6-DATE OF BIRTH

Unknown 1873
(Month) (Day) (Year)

7-AGE

43 yrs. 4 mos. 4 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Housekeeper9-BIRTHPLACE
(State or country)N.C.

PARENTS

10-NAME OF FATHER

Unknown11-BIRTHPLACE OF FATHER
(State or country)Unknown

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or country)Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Grace Marshall

(Address)

709 Sharp St

15-AUG 2 - 1915

ROBERT K. KRAUTH

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 30th 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April, 1915, to, July 30th 1915, that I saw him alive on July 29th 1915, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Chilvary Tuberculosisabout 2 1/2 mos

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Signed)

Wm. D. Lockwood M. D.
Aug 2nd 1915 (Address) P. E. Egan St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Int. Auburn CemAug 2 1915

20-UNDERTAKER

ADDRESS

John H. Joadern142 W. 11th St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 2812 E. Baltimore St.,

ST. 6 WARD)

FULL NAME

August C. Weber

(Residence in Baltimore: No. 2812 E. Baltimore St.,

St. 42 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6. DATE OF BIRTH Oct. 5th., 1862 (Month) (Day) (Year)

7. AGE 52 yrs. 9 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION (a) Trade, profession, or particular kind of work Bookkeeper (b) General nature of industry, business, or establishment in which employed (or employer) Brewery

9. BIRTHPLACE (State or country) Germany

10. NAME OF FATHER Christian Weber

11. BIRTHPLACE OF FATHER (State or country) Germany

12. MAIDEN NAME OF MOTHER Carlina Loos

13. BIRTHPLACE OF MOTHER (State or country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Lena Weber

(Address) 2812 E. Baltimore St.

15. AUG 2 - 1915 ROBERT KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 30, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19, 1915, to July 30, 1915, that I saw him alive on July 30, 1915, and that death occurred, on the date stated above, at 1:15 p.m. The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

Contributory (SECONDARY) Arterio Sclerosis

(Signed) J. C. Spadis M. D. 7/31/15 (Address) 437 W. 3rd May

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Baltimore Cemetery DATE OF BURIAL Aug. 2, 1915

20. UNDERTAKER Chas. E. Franck ADDRESS 802 Madison Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *6* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John T. McKay*(Residence in Baltimore: No. *222 N. Collington Ave.* St. *32* yrs. *4* mos. *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*4-COLOR OR RACE, *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*6-DATE OF BIRTH, *March 3, 1867*

(Month)

(Day)

(Year)

7-AGE, *48* yrs. *4* mos. *18* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Plumber*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Thomas McKay*11-BIRTHPLACE OF FATHER (State or Country), *Balto.*12-MAIDEN NAME OF MOTHER *Mary Baker*13-BIRTHPLACE OF MOTHER (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Katie McKay*(Address) *222 N. Collington Ave.*

15-

AUG 2 - 1915

ROBERT C. KRAUTER

Surial. Permit. Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 31, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 30, 1915, to July 31, 1915,*that I saw him alive on *July 31, 1915,*and that death occurred, on the date stated above, at *2 P. m.*

The CAUSE OF DEATH* was as follows:

Strangulated Umbilical Hernia.(Duration).....yrs.....mos.....ds. *4*CONTRIBUTORY (Secondary) *Hepatic Cirrhosis*(Duration).....yrs.....mos.....ds. *about 2*(Signed) *J. W. Vinton, Cliff* M. D.*July 31, 1915* (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos. *1* ds. In the State *Life* yrs.mos.ds.Where was disease contracted, if not at place of death? *unknown*Former or usual residence *222 N. Collington Ave.*19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer*DATE OF BURIAL, *Aug. 3, 1915*20-UNDERTAKER *Geo M. Fink*ADDRESS *811 N. Wolfe*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2122 Wilkens Ave* ST.; *70* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2122 Wilkens Ave* St.; *2* yrs., *24* mos. *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May 7, 1915
(Month) (Day) (Year)

7-AGE,

2 yrs., 24 mos., 24 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Balto. Md.*

10-NAME OF FATHER,

*Guthrie S. Hutchinson*11-BIRTHPLACE OF FATHER
(State or Country),*Balto. Md.*

12-MAIDEN NAME OF MOTHER

*Nellie V. Stearns*13-BIRTHPLACE OF MOTHER
(State or Country),*Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. S. L. Hutchinson*(Address) *2122 Wilkens Ave.*

15-

AUG 2 - 1915.

ROBERT KRAUTER,

Filed

Sur. Gen. Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 31, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 15, 1915, to July 31, 1915,*that I saw her alive on *July 31, 1915,*and that death occurred, on the date stated above, at *5 p m.*

The CAUSE OF DEATH* was as follows:

Acute enteritis(Duration) *2 ds.*CONTRIBUTORY
(Secondary)(Duration) *2 mos.*(Signed) *James H. Todd, M. D.**7-31, 1915.* (Address) *737 N. Drexel Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *2 yrs., 24 mos., 24 ds.* In the State *2 yrs., 24 mos., 24 ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Int. Olivet

DATE OF BURIAL,

Aug. 2, 1915.

20-UNDERTAKER

Geo. L. Schrab & Bro

ADDRESS

2101 Fredk Ave

CAUSE OF DEATH in plain language, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1419 Maryland Ave.* ST.; *11* WARD)FULL NAME *John A. Curtis*(Residence in Baltimore: No. *1419 Maryland Ave.* St.; *18* yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)6-DATE OF BIRTH, *Aug 1, 1880* (Month) (Day) (Year)7-AGE, *35* yrs., mos., ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Laborer* (b) General nature of industry, business, or establishment in which employed (or employer), *General*9-BIRTHPLACE, (State or Country), *St. Mary's Co Md*10-NAME OF FATHER, *John Curtis*11-BIRTHPLACE OF FATHER, (State or Country), *Md*12-MAIDEN NAME OF MOTHER, *Louisa Jenkins*13-BIRTHPLACE OF MOTHER, (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louisa Jenkins*(Address) *1419 Md Ave*

15-AUG 2 - 1915

Filed..... 191

ROBERT . KRAUTH, Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 1, 1915* (Month) (Day) (Year)17-HEREBY CERTIFY, That I attended deceased from *July 9* 1915, to *July 31* 1915, that I saw him alive on *July 31* 1915, and that death occurred, on the date stated above, at m.The CAUSE OF DEATH* was as follows: *Pulmonary Tuberculosis Indefinite* (Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary) (Duration) yrs., mos., ds.

(Signed) *P. G. Leonard* M.D. (Address) *424 - East 25 St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Laurel Cemetery*DATE OF BURIAL, *Aug 2, 1915*20-UNDERTAKER, *Sam'l F. Hendry*ADDRESS *578 W. Biddle*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87148

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hosp* ST.: *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *243 N. Poppleton* St. *35* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Black

5-SINGLE, .

Single

MARRIED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

April, 1880
(Month) (Day) (Year)

7-AGE,

35 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

Cook
Private Family

9-BIRTHPLACE,

(State or Country),

Maryland Baltimore

10-NAME OF FATHER,

Andrew Henry

11-BIRTHPLACE OF FATHER

(State or Country),

Delaware

12-MAIDEN NAME OF MOTHER

Mary Scott

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

AUG 2 - 1915

Filed

ROBERT

KRAUTER,

Bureau of Health

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, 31, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 29* 1915, to *July 31* 1915,that I saw her alive on *July 31* 1915,and that death occurred, on the date stated above, at *9 a.* m.

The CAUSE OF DEATH* was as follows:

Multiple fibroids of uterus
Appendicitis & Peritonitis(Duration) yrs. mos. ds. *7* ds.CONTRIBUTORY *Post operative shock*
(Secondary)(Duration) yrs. mos. ds. *1* ds.(Signed) *A. S. Coleman* M. D.*7/31*, 1915. (Address) *University Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *2* ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? *243 N. Poppleton*Former or usual residence *243 N. Poppleton St*

19-PLACE OF BURIAL OR REMOVAL,

St. Andrew

DATE OF BURIAL,

Aug 2 1915

20-UNDERTAKER

Samuel J. Neudorff 5787 Main

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1014 Vincent* ST.; *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *George Thomas*(Residence in Baltimore: No. *1014 Vincent* St.; *30* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

*colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) *Married*

6-DATE OF BIRTH.

Unknown, 1
(Month) (Day) (Year)

7-AGE,

32 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Labord*9-BIRTHPLACE,
(State or Country),*MD*

10-NAME OF FATHER,

*Thomas Thomas*11-BIRTHPLACE OF FATHER
(State or Country),*MD*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George Thomas*(Address) *1614 Vincent*

15-

AUG 2 - 1915

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 30, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 10* 1915, to *July 30* 1915, that I saw him alive on *July 30* 1915, and that death occurred, on the date stated above, at *8:30* pm.

The CAUSE OF DEATH* was as follows:

*asthma, secondary of heart*CONTRIBUTORY.....
(Secondary) *asthma heart*(Signed) *D. S. W. K. M. D.*
Aug 1, 1915 (Address) *708 E. Madison St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

108 Auburn

UNDERTAKER

James H. Davis

DATE OF BURIAL,

Aug 2, 1915

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7222 Vincent ST.; 16 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 7222 Vincent St.; 16 yrs., 1 mos., 1 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 27, 1886
(Month) (Day) (Year)

7-AGE,

28 yrs., 9 mos., 3 ds.If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....Labour
General9-BIRTHPLACE,
(State or Country),Balto. City Md.10-NAME OF
FATHER,Thos. Dorsey11-BIRTHPLACE
OF FATHER
(State or Country),Md.12-MAIDEN NAME
OF MOTHERSusie Cantel13-BIRTHPLACE
OF MOTHER
(State or Country),Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Susie Dorsey(Address).....7222 Vincent St.

15-AUG 2 - 1915

ROBERT . KRAUTH

Filed..... 191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 30, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
July 25 - 1915, to July 30 - 1915,
that I saw him alive on July 30 - 1915,
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)(Duration)..... yrs..... mos..... ds.
(Signed).....Chas. L. McParlin, M. D.
Aug. 2, 1915 (Address).....906 E. State St.*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Urban Aug. 2, 1915

20-UNDERTAKER

ADDRESS

James H. Dennis 1303 Chestnut

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Mersey Hospital* ST. *24* WARD)

2-FULL NAME

Andrew B. Anderson

(Residence in Baltimore: No. *1354 Towson Jr.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

6-DATE OF BIRTH,

May

17, 1879 (Month) (Day) (Year)

7-AGE,

36 yrs., *2* mos., *14* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

laborer
general

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Albert Anderson

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Nannah Huff

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Nannah Anderson

(Address)...

1354 Towson

15-

AUG 2 - 1915

ROBERT . KRAUTER

Filed.....

191.

Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 14, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, autopsy or inquiry.) and that said deceased came to his death of the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage, resulting from rupture of blood vessel of the kidney, the result of a accidental fall. (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Wm. M. Sargent* M. D. (Coroner.)

Aug. 2nd, 1915. (Address) *1724 Madison Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

at Locust Point

Former or usual residence *1354 Towson*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Belair Hill

Aug 8, 1915.

20-UNDERLIER

ADDRESS

Wm. M. Sargent

14th St. Bldg.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE	
CERTIFICATE OF DEATH	
1-PLACE OF DEATH	
CITY OF BALTIMORE: (No. <u>Johns Hopkins Hospital</u> ST. <u>7</u> WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
2-FULL NAME <u>Thomas Green Moore</u>	
(Residence in Baltimore: No. <u>none</u> (7 days in hospital) St. <u>7</u> yrs. <u>7</u> mos. <u>7</u> ds.)	
PERSONAL AND STATISTICAL PARTICULARS	
3-SEX <u>male</u>	4-COLOR OR RACE <u>white</u>
5-SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word)	
6-DATE OF BIRTH <u>Unknown</u> 11868 (Month) (Day) (Year)	
7-AGE <u>47</u> yrs. <u>4</u> mos. <u>7</u> ds. or min.?	
8-OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)	
9-BIRTHPLACE (State or country) <u>North Carolina</u>	
PARENTS	
10-NAME OF FATHER <u>not known by son</u>	11-BIRTHPLACE OF FATHER (State or country) <u>North Carolina</u>
12-MAIDEN NAME OF MOTHER <u>not known by son</u>	13-BIRTHPLACE OF MOTHER (State or country) <u>not known</u>
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Charles B. Thompson</u> (Address) <u>Johns Hopkins Hospital</u>	
15- <u>AUG 2 - 1915</u> <u>ROBERT . KRAUTH,</u> <u>Serial Permit Clerk</u> REGISTRAR	
MEDICAL CERTIFICATE OF DEATH	
16-DATE OF DEATH <u>August</u> 1, 1915 (Month) (Day) (Year)	
17- I HEREBY CERTIFY, That I attended deceased from <u>July 21</u> , 1915, to <u>Aug. 1</u> , 1915, that I saw him alive on <u>July 21</u> , 1915, and that death occurred, on the date stated above, at <u>10:47</u> a.m. The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u> <u>Miliary Tuberculosis</u>	
(Duration) <u>6</u> mos. <u>7</u> ds.	
Contributory (SECONDARY) (Duration) <u>7</u> yrs. <u>7</u> mos. <u>7</u> ds.	
(Signed), <u>Charles B. Thompson</u> M. D. <u>Aug. 1</u> , 1915. [Address] <u>Johns Hopkins Hosp.</u>	
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS] At place of death <u>7</u> yrs. <u>7</u> mos. <u>7</u> ds. In the State <u>7</u> yrs. <u>7</u> mos. <u>7</u> ds.	
Where was disease contracted, if not at place of death? <u>Southern</u> <u>U. S.</u>	
Former or usual residence <u>Southern</u> <u>U. S.</u>	
19-PLACE OF BURIAL OR REMOVAL <u>Franklin N. C.</u>	DATE OF BURIAL <u>Aug 2</u> , 1915
20-UNDERTAKER <u>Wm. C. Feltz</u>	ADDRESS <u>221 N. Broadway</u>

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hospital*) ST. *8* WARD
2-FULL NAME *Mary Sisin Fay*
(Residence in Baltimore: No. *1816 N. Chester Street* St. *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS
3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *married*
6-DATE OF BIRTH *Oct 8th 1876*
(Month) (Day) (Year)
7-AGE *38* yrs. *9* mos. *13* ds. or min.?
8-OCCUPATION (a) Trade, profession or particular kind of work *Sewing* (b) General nature of industry, business, or establishment in which employed (or employer) *at home*
9-BIRTHPLACE (State or country) *Maryland Balto*
PARENTS
10-NAME OF FATHER *August Sisin*
11-BIRTHPLACE OF FATHER (State or country) *Germany*
12-MAIDEN NAME OF MOTHER *Josephina Weitzman*
13-BIRTHPLACE OF MOTHER (State or country) *Germany*
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *P. Roszel*
(Address) *Johns Hopkins Hospital*

MEDICAL CERTIFICATE OF DEATH
16-DATE OF DEATH *July 30th 1915*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I attended deceased from *July 17th 1915*, to, *July 30th 1915*, that I saw her alive on *July 30th 1915*, and that death occurred, on the date stated above, at *10 P. m.*
The CAUSE OF DEATH* was as follows:
Intestinal Obstruction
Contributory (SECONDARY) *Operation - Peritonitis*
(Duration) yrs. 1 mos. ds.
(Signed) *Sander* M. D. *July 31st 1915* [Address] *Johns Hopkins Hospital*
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death yrs. mos. *13* ds. State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence *1816 N. Chester Street*
19-PLACE OF BURIAL OR REMOVAL *Baltimore Cemetery* DATE OF BURIAL *Aug 2nd 1915*
20-UNDERTAKER *A. Sander & Son* ADDRESS *1710 Fleet St.*

15- AUG 2 - 1915 ROBERT J. KRAUTER, Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hospital* ST. *8* WARD)

REGISTERED NO. C

2-FULL NAME

Richard J. Reschhausen

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1812 N. Collington Ave* St. *61* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

6-DATE OF BIRTH,

Oct 19, 1853
(Month) (Day) (Year)

7-AGE,

61 yrs. 9 mos. 18 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

Copper works

9-BIRTHPLACE,

(State or Country),

Ind

10-NAME OF FATHER,

Harry Reschhausen

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Eliza Fluiss

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Hermann A. Smith

(Address),

712 S. Lenoxwood Ave

15-

AUG 2 - 1915

ROBERT J. KRAUTER

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 31 1915, to Aug 1 1915,*that I saw him alive on *Aug 1 - 1915,*and that death occurred, on the date stated above, at *145X m.*

The CAUSE OF DEATH* was as follows:

Strang related homicide -

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Shock -

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Oscar V. Reinhardt* M. D.*Aug 1, 1915.* (Address) *St. Joseph Hs.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospital, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 1 ds. In the State 61 yrs. mos. ds.

Where was disease contracted, If not at place of death? *not known -*Former or usual residence *1812 N. Collington Ave*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Matthews Cem.**Aug 4, 1915*

20-UNDERTAKER

ADDRESS

H. Sander & Sons 1710 E. 11th St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

13 N. Bruce

ST.:

19

WARD)

REGISTERED NO. C

2-FULL NAME

Joseph Brown

(Residence in Baltimore: No.

13 N. Bruce

St.:

Life

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Unknown

1865

(Month)

(Day)

(Year)

7-AGE,

6-0 about

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

General

9-BIRTHPLACE,

(State or Country),

Md Balt

10-NAME OF FATHER,

Silas Brown

11-BIRTHPLACE OF FATHER

Md

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Miss Mollie Brown

(Address)

13 N. Bruce St

AUG 2 - 1915

ROBERT . KRAUTER

Filed....., 191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

29,

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

July 4, 1915, to July 29, 1915.

that I saw him alive on July 29, 1915.

and that death occurred, on the date stated above, at 1, 30, m.

The CAUSE OF DEATH* was as follows:

Cerebral Disease

(Duration)

yrs. mon. 25, ds.

CONTRIBUTORY (Secondary)

Heart Failure

(Duration)

yrs. mon. 25, ds.

(Signed)

M. D.

July 4, 1915 (Address) 412 S. Sharp

State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mon. ds. In the State yrs. mon. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

Aug 2, 1915

ADDRESS

Alfred J. Ireland 1445 Chas St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 N. Charles ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Virginia A. Turner(Residence in Baltimore: No. 817 N. Charles St St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widow (Write the word.)6-DATE OF BIRTH, unknown ? 1845 (Month) (Day) (Year)7-AGE, 70 yrs. mos. ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, at (b) General nature of industry, business, or establishment in which employed (or employer), Home9-BIRTHPLACE, (State or Country), Snow Hill Md.10-NAME OF FATHER, William Trunford11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER Eleanor Holland13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George J. Turner(Address) 817 N. Charles St.

15-AUG 2 - 1915, ROBERT . KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug, 1, 1915. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 1915, to Aug 1915, that I saw he alive on Aug, 1915, and that death occurred, on the date stated above, at 10⁴⁰ p.m.

The CAUSE OF DEATH* was as follows:

Diphtheria - adenoiditis (Duration) 5 yrs. mos. ds.CONTRIBUTORY Diphtheria come (Secondary)(Signed) J. Frederick Long M. D. 8/2-15, 191... (Address) 2040 International

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New-Cathedral AveAug 3, 1915

20-UNDERTAKER

ADDRESS

Henry W. Jenkins Sons & CoW. M. Mott & Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

687157

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *946 Harlem Ave* ST.; *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

2-FULL NAME *Amanda Sappington*(Residence in Baltimore: No. *946 Harlem Ave* St.; *81* yrs., *15* mo., *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

July 15, 1834
(Month) (Day) (Year)

7-AGE,

81 yrs., *15* mos., *15* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Balto.*

10-NAME OF FATHER,

*Gerard H Sappington*11-BIRTHPLACE OF FATHER
(State or Country),*Harford Co.*

12-MAIDEN NAME OF MOTHER

*Eliq. Bailey*13-BIRTHPLACE OF MOTHER
(State or Country),*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Saura Sappington

(Address)

946 Harlem Ave

15-

AUG 2 - 1915

ROBERT . KRAUTER

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 31, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 14, 1915* to *July 31, 1915*, that I saw her alive on *July 31, 1915*, and that death occurred, on the date stated above, at *6:30 P* m.

The CAUSE OF DEATH* was as follows:

Acute Dysentery(Duration) yrs. mos. *17* ds.CONTRIBUTORY
(Secondary)*Hypostatic Pneumonia*(Duration) yrs. mos. *2* ds.(Signed) *Okiebur Freeman* M. D.*Aug. 2, 1915* (Address) *1227 W. Fayette Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Green Mount**Aug. 2, 1915*

20-UNDERTAKEN

ADDRESS

C. M. Mitchell & Co. 1227 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1028 Wilcox* ST.; *10* WARD)2-FULL NAME *John W. Scott*(Residence in Baltimore: No. *1028 Wilcox*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *11* yrs., *11* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

Aug 30 - 1914
(Month) (Day) (Year)

7-AGE,

11 yrs., *11* mos., *—* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

*None*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*Harry E. Scott*11-BIRTHPLACE OF FATHER
(State or Country),*B. Baltimore*

12-MAIDEN NAME OF MOTHER

*Ellen M. Park*13-BIRTHPLACE OF MOTHER
(State or Country),*Washington D.C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry E. Scott*(Address) *1028 Wilcox St.*

15-

AUG 2 - 1915
Filed*ROBERT K. KRAUTH*
Official Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 31, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 26, 1915, to July 31, 1915,
that I saw him alive on *July 27, 1915,*
and that death occurred, on the date stated above, at *7:15 P.M.*

The CAUSE OF DEATH* was as follows:

Cholera Infantum
(Catarrhal Enteritis)
(Duration) *1* yrs., *1* mon., *—* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs., *1* mon., *—* ds.
(Signed) *W. C. Burns* M. D.
July 31, 1915. (Address) *2218 S. Pratt*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *11* yrs., *11* mos., *—* ds. In the State *11* yrs., *11* mos., *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Aug. 2, 1915.

20-UNDERTAKER,

ADDRESS

H. C. Wiedefeld 914 Greenmount
an

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1230 E North Ave ST.; 9 WARD)FULL NAME Eugene A. Walter

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1230 E North Ave St.; — yrs., — mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word.)6-DATE OF BIRTH, July 31, 1915
(Month) (Day) (Year)7-AGE, 1 ds. If LESS than 1 day, 4 hrs. or — min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, Anthony Walter11-BIRTHPLACE OF FATHER (State or Country), Baltimore12-MAIDEN NAME OF MOTHER Clara Kormick13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony J. Walter(Address) 1230 E North Ave15- AUG 2 - 1915 ROBERT J. KRAUTERFiled..... 191.. Aug 2.. Perm..
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 2, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from July 31 1915, to August 1 1915, that I saw him alive on August 1 1915, and that death occurred, on the date stated above, at 1.4 m.

The CAUSE OF DEATH* was as follows:

Inanition - due to strangulation of fetal cord in breast
(Duration)..... yrs..... mos. 1 ds.

CONTRIBUTORY..... (Secondary)

(Duration)..... yrs..... mos. 1 ds.(Signed) J. J. K. K. K. M. D.August 1 1915. (Address) 1.4.1. Maryland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos. 1 ds. In the State..... yrs..... mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, Aug 2, 1915.20-UNDERTAKER William Cook ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8

ST.: 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 8

St.: yrs. 4 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

Colored

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

single

6-DATE OF BIRTH,

unknown, 1

(Month)

(Day)

(Year)

7-AGE,

4

yrs. mos. da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

Niel

9-BIRTHPLACE,

(State or Country),

Baltimore md

10-NAME OF FATHER,

Saunders French

11-BIRTHPLACE OF FATHER (State or Country),

Gloucester Va

12-MAIDEN NAME OF MOTHER

Annie B. Ellis

13-BIRTHPLACE OF MOTHER (State or Country),

Gloucester Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Name Annie B. French

(Address)

8 W. Lavelle St

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 1st, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 28 1915, to August 1st 1915.

that I saw him alive on August 1st 1915.

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

extremities

(Duration)

7 mos. 1 da.

CONTRIBUTORY (Secondary)

Heart failure

(Duration)

1 da.

(Signed)

Reginald S. Conroy M. D.

1915

(Address) 4142 North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

da.

In the State

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mt Auburn Cem

Aug 3, 1915

20-UNDERTAKER

Pete B. Pye

ADDRESS

1028 Mulberry

18-

AUG 2 - 1915

ROBERT K. KRAUTH

Burial Permit Clerk

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *342 E. 20th St.* ST. *12* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Isabella McLaughlin*(Residence in Baltimore: No. *342 E. 20th St.* St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *Unknown*

(Month)

(Day)

(Year)

7-AGE, *About 65*

yrs.

mos.

ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *at home*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Baltimore Md.*10-NAME OF FATHER, *James E. McLaughlin*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore Md.*12-MAIDEN NAME OF MOTHER *Lucy E. Jordan*13-BIRTHPLACE OF MOTHER (State or Country), *Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles E. McLaughlin*(Address) *405 E. North Ave.*

15-

AUG 2 - 1915

HARRY O. ANDREWS

Baltimore, Md.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 30th 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 13* 1915, to *July 30* 1915, that I saw *her* alive on *July 30* 1915, and that death occurred, on the date stated above, at *1 A* m.

The CAUSE OF DEATH* was as follows:

*Paralysis**2nd Stroke*

(Duration).....

yrs.

mos.

ds. *17*CONTRIBUTORY (Secondary) *Apoplexy*

(Duration).....

yrs.

mos.

ds. *17*(Signed) *Reginald J. Conry* M. D.*July 31, 1915* (Address) *414 E. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutional Transients, or Recent Residents).

At place of death.....

yrs.

mos.

ds.

In the

State.....

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Cathedral Cemetery*DATE OF BURIAL, *Aug. 3, 1915*UNDERTAKER *Henry W. McLaughlin*ADDRESS *805 N. Calvert St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1327 Valley* ST.; *9* WARD)FULL NAME *James J. Burns*(Residence in Baltimore: No. *1327 Valley* St.; yrs., *10* mos. *19* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Sept 13, 1914 (Month) (Day) (Year)

7-AGE,

10 yrs., *19* mos., *19* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Edward P. Burns

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Catherine Koschart

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward P. Burns*(Address) *1327 Valley St.*

15-

Filed

AUG 2 - 1915

191

HARRY O. BARKER
BAPTIST FORMERLY Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 1, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 28* 1915, to *Aug 1* 1915, that I saw him alive on *Aug 1* 1915, and that death occurred, on the date stated above, at *2:30* a.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum
(Duration).....yrs.....mos. *5* ds.

CONTRIBUTORY (Secondary)

(Signed) *John D. Reck* M. D.
Aug 2 1915. (Address) *936 E. Monument St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cean

DATE OF BURIAL,

Aug 3, 1915.

20-UNDERTAKER

H. O. Medefeld

ADDRESS

914 Green St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87163

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87163

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Sr. 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

IF LESS than 1 day, hrs. or mo.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on and that death occurred, on the date stated above, at 3:30 P.M. The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed), M. B. Cum and Local M. D. Aug 1, 1915 (Address) 626 N. 9th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

AUG 2 - 1915

Filed

191

HARRY O. ANDREWS, Registrar

REGISTRAR

Annapolis Md

Aug. 4, 1915

Joe B Cook

1003 W. Baltimore St

It is very important. See instructions on back of certificate.

87164

HEALTH DEPARTMENT--CITY OF BALTIMORE

87164

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *904 N. Monroe*

ST. *16* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Henry C. Bulman*

(Residence in Baltimore: No. *904 N. Monroe*

St. *64* yrs. *6* mos. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

April

4, *1847*

(Month)

(Day)

(Year)

7-AGE

68

yrs.

3

mos.

27

ds.

If LESS than
1 day,.....hrs.
or.....min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Shoe Maker

9-BIRTHPLACE

(State or country)

Germany

10-NAME OF FATHER

Daniel H. Bulman

11-BIRTHPLACE OF FATHER

(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Elizabeth Bachman

13-BIRTHPLACE OF MOTHER

(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Caroline Bulman

(Address)

904 N. Monroe St

15-AUG 2 - 1915

Filed

, 191

HARRY O. ANDREWS

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July

31

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

Aug

1914

to

date of death

1915

that I saw him alive on

July 31

1915

and that death occurred, on the date stated above, at *11:30* m.

The CAUSE OF DEATH* was as follows:

*Death was due to
Acute Myocarditis of
about 18 (Duration) yrs. 10 mos. 15 ds.*

Contributory
(SECONDARY)

(Signed)

Dr. Henry L. Davis

M. D.

July 31, 1915

(Address)

824 N. Tuckman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cem

Aug 3, *1915*

20-UNDERTAKER

ADDRESS

E. Schlanman & Son

1039 N. Tuckman St

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 3350 Hickory Avenue 13 WARD)

2-FULL NAME

Ella Mary Holt

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3350 Hickory AveSt.; yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

single

6-DATE OF BIRTH

Jan91905

7-AGE

10yrs. 6mos. 21ds. If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)none

9-BIRTHPLACE

(State or country)

Elliott City Md10-NAME OF
FATHERWm G Holt11-BIRTHPLACE
OF FATHER
(State or country)West Virginia12-MAIDEN NAME
OF MOTHERAgnes C Bohrer13-BIRTHPLACE
OF MOTHER
(State or country)West Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Agnes C Holt

(Address)

3350 Hickory Ave

15-

AUG 2 - 1915

HARRY O. ANDREWS,

MARIAL FORM 10-1-15

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 1st191517- I HEREBY CERTIFY, That I attended deceased from
May 14th, 1915, to, Aug 1st, 1915,
that I saw her alive on on Aug 1st, 1915,
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heartContributory
(SECONDARY)(Signed), Arthur Williams M. D.
Aug 2, 1915. [Address] Elk Ridge House

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State yrs. mos. ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elk Ridge Cem Aug 4, 191520-UNDERTAKER Le Roy Stepler ADDRESS 844 W 36th

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE, (No. *Franklin Sq. Ws.*, ST. *7* WARD)

2-FULL NAME

Chas. E. Wengate(Residence in Baltimore: No. *519 N Washington* St.; *68* yrs., *9* mos., *8* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widowed*

6-DATE OF BIRTH,

Oct 22, 1846
(Month) (Day) (Year)

7-AGE,

68 yrs., *9* mos., *8* ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *Painter*
(b) General nature of industry, business, or establishment in which employed (or employer)... *retired 10 yrs*

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

William Wengate

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo M. Cate*(Address) *509 N Washington*

15-

AUG 2 - 1915

HARRY O. ANDREWS,

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 1, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 16, 1915*, to *Aug. 1, 1915*, that I saw him live on *Aug 1, 1915*, and that death occurred, on the date stated above, at *2:15 a.m.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) *6* yrs., *6* mos., *6* ds.

CONTRIBUTORY (Secondary)

(Duration) *6* yrs., *6* mos., *6* ds.(Signed) *Geo. A. Smith* M. D.*Aug 1, 1915* (Address) *Franklin Sq. Ws.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *15* ds. In the State *Lifetime* ds.Where was disease contracted, if not at place of death? *at Home*Former or usual residence *519 N Washington*

19-PLACE OF BURIAL OR REMOVAL,

Greenmount

DATE OF BURIAL,

Aug 3, 1915

20-UNDERTAKER

Herwig & Co

ADDRESS

2008 Greenmount

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B. - Every item of information should be carefully supplied. No statement of OCCUPATION is to be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87167

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87167

CERTIFICATE OF DEATH

PLACE OF DEATH *950 W Davatoga* ST. *18* WARD) REGISTERED NO. C *28*
CITY OF BALTIMORE: (NO *950 W Davatoga* ST. *18* WARD)
2-FULL NAME *Robert L Duncan*
(Residence in Baltimore: No. *950 W Davatoga* St.; *27* yrs. *2* mos. *11* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

1-SEX *Male* 4-COLOR OR RACE *Cauc* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
6-DATE OF BIRTH *Unknown* 1888
(Month) (Day) (Year)
7-AGE *27* yrs. *2* mos. *11* ds. or min.?
8-OCCUPATION *Wagon Driver*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE *Balto*
(State or country)
10-NAME OF FATHER *Robert L Duncan*
11-BIRTHPLACE OF FATHER *Md.*
(State or country)
12-MAIDEN NAME OF MOTHER *Belle Gordon*
13-BIRTHPLACE OF MOTHER *Va*
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Robert L Duncan*
(Address) *950 W Davatoga*

15-AUG 2 - 1915
MARIAL PERMIT CLERK
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *July 31, 1915*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I attended deceased from *June 1, 1915*, to *July 31, 1915*, that I saw h... alive on *July 30, 1915*, and that death occurred, on the date stated above, at *11 P. m.*
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(Duration) *8* yrs. *8* mos. *8* ds.
Contributory (SECONDARY) *absorption of food*
(Duration) *1* yrs. *1* mos. *1* ds.
(Signed) *W. H. M. D.*
(Address) *939 W. 7th St.*
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death *27* yrs. *2* mos. *11* ds. In the State *27* yrs. *2* mos. *11* ds.
Where was disease contracted, if not at place of death?
Former or usual residence
19-PLACE OF BURIAL OR REMOVAL *St. Andrew* DATE OF BURIAL *Aug 3, 1915*
ADDRESS *316 N. Hill St. Mount St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 N Bruce ST.; 19 WARD)2-FULL NAME Elizabeth Green(Residence in Baltimore: No. 410 N Bruce St.; 19 yrs., 5 mos., 5 ds.)151
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX Female4-COLOR OR RACE, Black

5-SINGLE

Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH:

Jul 28, 1915
(Month) (Day) (Year)

7-AGE,

5 yrs., 5 mos., 5 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), Md (City)10-NAME OF FATHER, Louis Green11-BIRTHPLACE OF FATHER (State or Country), Md12-MAIDEN NAME OF MOTHER Emma Johnson13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Alvin Melchior(Address).....Mercy Hospital

15-AUG 2 - 1915

HARRY O. ANDREWS,

Filed....., 191...

Serial Permit. Olor

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jul 28 1915, to Aug 2 1915that I saw her alive on Aug 1 1915,and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....

.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....

..... (Duration)..... yrs..... mos..... ds.

(Signed) Edward P. Smith M. D.Aug 2, 1915 (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, 410 N. Bruce St

if not at place of death?

Former or usual residence 410 N. Bruce St

19-PLACE OF BURIAL OR REMOVAL,

St Peter Can

DATE OF BURIAL,

Aug 3, 1915

20-UNDERTAKER

Robert BrownADDRESS 356 NMount St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87169

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64

C87169

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

29 S. Arlington Ave. 18 WARD)
Kate Rouke
29 S. Arlington Ave. St. 77 yrs. 5 mos. 4 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widow

6 DATE OF BIRTH

Feb. 28, 1838
(Month) (Day) (Year)

7 AGE

77 yrs. 5 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

Baltimore Md

10 NAME OF FATHER

John Russell

11 BIRTHPLACE OF FATHER (State or country)

France

12 MAIDEN NAME OF MOTHER

Charlotte Dreck

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Howard Sullivan
79 So. Arlington Ave.
(Address)

15

AUG 2 - 1915

HARRY O. ANDREWS,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 1, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20, 1915, to Aug. 1, 1915.
that I saw her alive on August 1, 1915,
and that death occurred, on the date stated above, at 5 p. m.
The CAUSE OF DEATH* was as follows:

Cerebral Congestion

(Duration) — yrs. — mos. one ds

Contributory Hot weather & The in-
(SECONDARY)
firmities of old age
(Signed) John H. Wood, M. D.
August 2, 1915 (Address) 630 N. Gilman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

St. Olivet Cem

DATE OF BURIAL

Aug. 3, 1915

20 UNDERTAKER

Joe Clark

ADDRESS

1003 N. Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 169

C87170

PLACE OF DEATH

CITY OF BALTIMORE (NO. *Foot of Pier 7, Belmont St.*)

WARD

FULL NAME

William H. Pundelbury (Pundelbury)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *none*)

St.: yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

....., *1880*.....
(Month) (Day) (Year)

7-AGE,

35

..... yrs. — mos. — ds.

If LESS than 1 day,
..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Fireman

(b) General nature of industry, business, or establishment in which employed (or employer).

S. M. M. Co.

9-BIRTHPLACE, (State or Country),

Unknown

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *Paler, Sergeant*

(Address)..... *Eastern District*

15-

AUG 2 - 1915

Filed

191

HARRY O. ANDREWS,

Marital Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 1, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-

..... and that said deceased came to..... death
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... *V. W. Jones*..... M. D.
(Coroner.)

Aug 2, 1915 (Address)..... *316 W. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cem

DATE OF BURIAL,

Aug 3, 1915

20-UNDERTAKER

Joseph Cook

ADDRESS

103 N. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2304 Jefferson* ST.; *7* WARD)

2-FULL NAME

Robert Ray Hamilton(Residence in Baltimore: No. *2304 Jefferson* St.; yrs., mos. *7* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Single*

6-DATE OF BIRTH,

June 25, 1915
(Month) (Day) (Year)

7-AGE,

1 yrs. *7* mos. *7* ds.
..... hrs. or min.?

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work..... *None*

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Md (City)*

10-NAME OF FATHER,

Thomas J. Hamilton

11-BIRTHPLACE

OF FATHER
(State or Country), *Md*

12-MAIDEN NAME

OF MOTHER *Alice B. Dopen*

13-BIRTHPLACE

OF MOTHER
(State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *Thomas J. Hamilton*(Address)..... *2304 Jefferson St*

15-

AUG 2 - 1915

HARRY O. ANDREWS

Filed..... 1915

MARIAL POINT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 26, 1915, to Aug 1, 1915,*that I saw him alive on *July 31, 1915,*and that death occurred, on the date stated above, at *7:45 P. m.*

The CAUSE OF DEATH* was as follows:

Measles(Duration)..... yrs. mos. *6* ds.

CONTRIBUTORY

(Secondary)..... *Gastro-enteritis*

(Duration)..... yrs. mos. ds.

(Signed)..... *Harry O. Andrews* M. D......, 1915. (Address)..... *2304 Jefferson St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Lorram Cemetery

20-DATE OF BURIAL,

Aug 3, 1915

21-UNDERTAKER

Christian Miller 2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

087172

1-PLACE OF DEATH

104
6
REGISTERED NO. C

CITY OF BALTIMORE (No. 2607 E. Fairmount Ave St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret B. Dremling

(Residence in Baltimore: No. 2607 E. Fairmount Ave Sr. yrs. 2 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

May 23, 1915
(Month) (Day) (Year)

7-AGE

2 yrs. 8 mos. 8 ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Md (City)

10-NAME OF FATHER

John F. Dremling

11-BIRTHPLACE OF FATHER (State or country)

Md

12-MAIDEN NAME OF MOTHER

Henrietta Rehnis

13-BIRTHPLACE OF MOTHER (State or country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John F. Dremling

(Address)

2607 E. Fairmount Ave

15-

AUG 2 - 1915

HARRY O. ANDREWS,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 31, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 29, 1915, to, July 31, 1915.

that I saw her alive on July 30, 1915.

and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) — yrs. — mos. 5 ds

Contributory (SECONDARY)

(Duration) — yrs. — mos. — ds.

(Signed) J. P. C. Jones M. D.

July 29, 1915 (Address) 2600 E. Fairmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

Aug 4, 1915

UNDERTAKER

ADDRESS

Christina Miller 2331 Jefferson St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *937 N Wolfe* ST.: *7* WARD)2-FULL NAME *Josephine Otčenášek*(Residence in Baltimore: No. *937 N Wolfe* St.: *36* yrs. mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Nov. 29, 1915
(Month) (Day) (Year)

7-AGE,

65

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

Housewife

9-BIRTHPLACE,

(State or Country),

Austria

10-NAME OF FATHER,

Sebastian Trout

11-BIRTHPLACE OF FATHER

(State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Princess Newman

13-BIRTHPLACE OF MOTHER

(State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Frank Otčenášek

(Address).....

937 N Wolfe St

15-

AUG 2 - 1915.

Filed.....

191

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 1, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from
July 29, 1915, to *Aug 1, 1915*,
that I saw him alive on *Aug 1, 1915*,
and that death occurred, on the date stated above, at *3 P. m.*

The CAUSE OF DEATH* was as follows:

*Cerebral Hemorrhage*CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

Coronary Dilatation

(Duration).....yrs.....mos.....ds.

(Signed).....

Aug 2, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

Aug 4, 1915.

20-UNDERTAKER

Frank Grachson

ADDRESS

19046 Cylindre

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3506 Roland Ave.* ST. *13* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John J. Simpson*(Residence in Baltimore No. *3506 Roland Ave.* St. *27* yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *June 22, 1849*

(Month)

(Day)

(Year)

7-AGE, *66* yrs. *1* mos. *12* ds.

If LESS than 1 day. hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Machinist*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Va.*10-NAME OF FATHER, *Geo. Simpson*11-BIRTHPLACE OF FATHER (State or Country), *Wales.*12-MAIDEN NAME OF MOTHER *Catherine B. Jones*13-BIRTHPLACE OF MOTHER (State or Country), *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Geo. Simpson*(Address) *3639 Falls Road*

15-

AUG 3 - 1915

ROBERT KRAUTER,

Filed

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 30, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr 4* 1915, to *August 3* 1915, that I saw him alive on *Aug 2nd* 1915, and that death occurred, on the date stated above, at *3:30* Am.

The CAUSE OF DEATH* was as follows:

*Intestinal affection
a tumor of stomach believed
to be carcinoma no operation*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Unknown*

(Duration) yrs. mos. ds.

(Signed) *Geo. H. Burgee M. D.**Aug 3rd*, 1915. (Address) *21 or 25 R St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mary's (Hamden) Aug 5, 1915

20-UNDERTAKER

ADDRESS

Horace Burgee 3639 Falls Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *15* ST.; *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1721 N. Monroe* St.; *25* yrs., *0* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Sept. 1898
(Month) (Day) (Year)

7-AGE,

37
yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*
*General*9-BIRTHPLACE,
(State or Country),*England*

10-NAME OF FATHER,

*Harrie Wolfe*11-BIRTHPLACE OF FATHER
(State or Country),*England*

12-MAIDEN NAME OF MOTHER

*Annal Brown*13-BIRTHPLACE OF MOTHER
(State or Country),*England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert Krauth*(Address) *1721 N. Monroe St.*

15-

*AUG 3 - 1915**ROBERT . KRAUTH*

Filed....., 191...

MARIAL PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 3, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 27, 1915, to *Aug 3, 1915*that I saw him alive on *Aug 3, 1915*and that death occurred, on the date stated above, at *6:00 a.m.*

The CAUSE OF DEATH* was as follows:

Encephalitis of Pons

.....

..... (Duration) yrs. mos. *12* ds.CONTRIBUTORY
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *Edward J. Smith* M. D.*Aug 3, 1915* (Address) *1721 N. Monroe St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *7* ds. In the *35* yrs. mos. ds. State *MD*Where was disease contracted, if not at place of death? *1721 N. Monroe St.*Former or usual residence *1721 N. Monroe St.*

19-PLACE OF BURIAL OR REMOVAL,

Washington PG

DATE OF BURIAL,

Aug 4, 1915

20-UNDERTAKER

Spies & Suddern

ADDRESS

118 N. Mt. Rainier

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *656 W. Franklin St.* ST. *4* WARD)

2-FULL NAME *John Q. Leonard*

(Residence in Baltimore: No. *656 W. Franklin St.* ST. *4* WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Nov 5 1872

(Month)

(Day)

(Year)

7-AGE

42

8

27

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Police

9-BIRTHPLACE

(State or country)

Ireland

10-NAME OF FATHER

John J. Leonard

11-BIRTHPLACE OF FATHER

Ireland

12-MAIDEN NAME OF MOTHER

Margaret M. Monahan

13-BIRTHPLACE OF MOTHER

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sms Jno J. McCarthy

(Address)

656 W. Franklin St.

16-DATE OF DEATH

Aug 1

1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 1, 1915, to Aug 1, 1915,

that I saw him alive on *July 31, 1915,*

and that death occurred, on the date stated above, at *11:30* m.

The CAUSE OF DEATH* was as follows:

Pneumonia, fulminant

Contributory (SECONDARY)

Heart

(Signed)

Harry B. Pratt

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

Aug 4, 1915

20-UNDERTAKER

G. F. Walker 723 W. 1st St.

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Eulaw Place ST. 14 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1407 Eulaw Place St. 2 yrs. 6 mos. 23 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)6-DATE OF BIRTH. January 9, 1913 (Month) (Day) (Year)7-AGE. 2 yrs. 6 mos. 23 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). none9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, B. F. Bond11-BIRTHPLACE OF FATHER (State or Country), Baltimore12-MAIDEN NAME OF MOTHER Mary Levering13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. F. Bond(Address) 1407 Eulaw Place15-AUG 3 - 1915
Filed..... 191.....

ROBERT K. KRAUTER

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 1, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 19, 1915, to August 1, 1915, that I saw him alive on August 1, 1915, and that death occurred, on the date stated above, at 10⁰⁹ m.

The CAUSE OF DEATH* was as follows:

Aleocolitis (Dysentery)
(Duration)..... yrs. mos. 13 ds.

CONTRIBUTORY..... (Secondary).....

(Signed) Leus P. Hamburg M. D.
Aug 2, 1915 (Address) 1407 Eulaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Green Mt. Cemetery Aug 3, 191520-UNDERTAKER ADDRESS Stewart Mowen Co 108 W North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 N. Brehm ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 416 N. Brehm St. St.; yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH.

July 26, 1915
(Month) (Day) (Year)

7-AGE.

7 yrs., mos. ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).None

9-BIRTHPLACE.

(State or Country),

Baltimore Md.

10-NAME OF FATHER.

Joseph Thompson

11-BIRTHPLACE OF FATHER (State or Country).

Md.

12-MAIDEN NAME OF MOTHER

Anna Williams

13-BIRTHPLACE OF MOTHER (State or Country).

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert A. Elliott(Address) Calvert St.15 AUG 3 - 1915ROBERT A. ELLIOTTCorial Parrot Olay

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 26, 1915, to Aug 2, 1915that I saw her alive on Aug 1, 1915and that death occurred, on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Violent Birth-Invasion

(Duration)....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs.....mos.....ds.

(Signed) Edward J. Smith M. D.Aug 2, 1915 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? 416 N. Brehm St.Former or usual residence 416 N. Brehm St.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Ambrose CemeteryAug 3, 1915

20-UNDERTAKER

ADDRESS

Robert A. Elliott504 Rodgers

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *7* WARD)2-FULL NAME *Elizabeth Manley*

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 10.)

(Residence in Baltimore: No. *Johns Hopkins Hosp* St. *7* yrs. *4* mos. *ds.*)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, *hrs.*
or *min.*?

8-OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)9-BIRTHPLACE
(State or country)10-NAME OF
FATHER11-BIRTHPLACE
OF FATHER
(State or country)12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on *Aug 1*, 1915,
and that death occurred, on the date stated above, at *7 a.m.*

The CAUSE OF DEATH* was as follows:

*Myocarditis - Chronic Endocarditis
(Heart Insufficiency)*Contributory
(SECONDARY)

(Signed)

Aug 1, 1915 [Address] *Johns Hopkins Hosp*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *114* yrs. *114* mos. *ds.* State *✓* yrs. *✓* mos. *ds.*Where was disease contracted,
if not at place of death?Former or usual residence *1316-1st St. Canton*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

AUG 3 - 1915

ROBERT KRAUTER,

Filed *191*

Serial Permit REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. This statement of OCCURRENCE is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Joseph Hospital

ST.

9

WARD)

REGISTERED NO. C.

2-FULL NAME

Joseph Kiedoff

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

St. Joseph Hospital

St.: yrs. mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

unknown

1915

(Month)

(Day)

(Year)

7-AGE,

✓

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

Baby

9-BIRTHPLACE,

(State or Country),

Balto City

10-NAME OF FATHER,

John Kiedoff

11-BIRTHPLACE OF FATHER (State or Country),

Balto

12-MAIDEN NAME OF MOTHER

S. S. S. S. S.

13-BIRTHPLACE OF MOTHER (State or Country),

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Kiedoff

(Address)

Perry Hall

15-

AUG 3 - 1915

ROBERT KRAUTER,

Filed 1915 Serial Form Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 1

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 1 1915, to Aug 1 1915,

that I saw him alive on Aug 1 1915,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Bronchitis

(Duration) yrs. mos. ds.

(Signed) Oscar J. S. S. S.

Aug. 2, 1915 (Address) St. Joseph Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? not known

Former or usual residence Perry Hall Md

19-PLACE OF BURIAL OR REMOVAL,

Holy Cross

DATE OF BURIAL,

Aug 3, 1915

20-UNDERTAKER

C. B. Kiedoff Green Mt.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

AUG 3 -- 1915

ROBERT KRAUTER,

Morial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on and that death occurred, on the date stated above, at 11.50 Am.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C67182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4*)ST. *4*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *4*)St.; yrs., mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Aug. 2, 1863.
(Month) (Day) (Year)

7-AGE,

*52 yrs., 0 mos., 1 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Brotherhood*
*Woodstock College*9-BIRTHPLACE,
(State or Country),*Bavaria*

PARENTS.

10-NAME OF FATHER,

*Michael Ritter*11-BIRTHPLACE OF FATHER
(State or Country),*Bavaria*

12-MAIDEN NAME OF MOTHER

*Elizabeth Stern*13-BIRTHPLACE OF MOTHER
(State or Country),*Bavaria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

AUG 3 - 1915

ROBERT

KRAUTER

Sur. Gen. Harold A. Clark

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 3, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Aug 1 191*5*, to *Aug 3* 191*5*,
that I saw him alive on *Aug 3* 191*5*,
and that death occurred, on the date stated above, at *1200* m.

The CAUSE OF DEATH* was as follows:

Pericarditis
General Peritonitis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)*Diabetes Mellitus*

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

Aug 3, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the *Woodstock Md.* State.....yrs.....mos.....ds.Where was disease contracted, if not at place of death? *Woodstock Md.*Former or usual residence *Woodstock Md.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Woodstock College Cemetery**Aug 5, 1915*

20-UNDERTAKER

ADDRESS

*S. Killinger & Son**Ellicott City*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

Hahnemann General Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1122 N. Mount

ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

James Franklin

(Residence in Baltimore: No. 1304 N. Bruce

St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

29

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Hotel Porter

(b) General nature of industry, business, or establishment in which employed (or employer).

Hotel Porter

9-BIRTHPLACE,

(State or Country).

Lexington Kentucky

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country).

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

The Trustee

(Address)

1304 N. Mount St.

15-

AUG 3 - 1915

ROBERT E. RAUTER,

Filed

191

Burial Permit 0122

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August

(Month)

2

(Day)

1915

17- I HEREBY CERTIFY, That I attended deceased from

Aug 2 1915, to Aug 2 1915,

that I saw him alive on August 2 1915,

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Strangulated inguinal hernia since Wednesday last.

(Duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Great heat (76°)

(Signed) H. H. Stensbury

Aug 2, 1915 (Address) 920 N. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 1 ds. In the State yrs. 10 mos. ds.

Where was disease contracted, if not at place of death? 1304 N. Bruce St.

Former or usual residence 1304 N. Bruce St.

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

Aug 3, 1915

20-UNDERTAKER

James H. Dennis 1303 Lexington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 N. Parrish ST.; 16 WARD)

2-FULL NAME

William Smith

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1225 N. ParrishSt.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

Colored5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) Single

6-DATE OF BIRTH.

Not known

(Month)

(Day)

(Year)

7-AGE,

49yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Watchman
Railroad

9-BIRTHPLACE,

(State or Country),

Not known

PARENTS.

10-NAME OF FATHER,

Not known

11-BIRTHPLACE

OF FATHER
(State or Country),Not known

12-MAIDEN NAME

OF MOTHER

Not known

13-BIRTHPLACE

OF MOTHER
(State or Country),Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Peter Leppert

(Address).....

Cor. Lawrence St. & Parrish St.

15-

Filing

AUG 3 - 1915, ROBERT K. KROGER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug.11915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 22, 1915, to July 31, 1915,that I saw him alive on July 31, 1915,and that death occurred, on the date stated above, at 5-6 PM.

The CAUSE OF DEATH* was as follows:

Probably gastric
serositis
indefinite(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)(Duration) yrs. mos. ds.(Signed) Chas. C. McCondy M. D.Aug 3, 1915, (Address) 906 N. St. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Not knownAug 3, 1915

20-UNDERTAKER

ADDRESS

James H. Davis 1303 Chestnut

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2217 Oak* ST.; *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Elizabeth Mathews*(Residence in Baltimore: No. *2217 Oak* St.; *35* yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widow*

6-DATE OF BIRTH *Nov 22, 1839*
(Month) (Day) (Year)

7-AGE *75*
yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *England*

10-NAME OF FATHER, *William Trezise*

11-BIRTHPLACE OF FATHER (State or Country), *England*

12-MAIDEN NAME OF MOTHER *Eliza Harris*

13-BIRTHPLACE OF MOTHER (State or Country), *England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Philip Turner*(Address) *2217 Oak St*

15-

Filed

AUG 3 - 1915

ROBERT

KRAPE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *Aug 1, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 25, 1915*, to *July 31, 1915*, that I saw her alive on *July 31, 1915* and that death occurred, on the date stated above, at *6:30 a.m.*

The CAUSE OF DEATH* was as follows:

Chronic Vascular Heart Disease
(Duration) *unknown*

CONTRIBUTORY (Secondary)

(Signed) *Walter H. Cox* M. D.
8-2, 1915 (Address) *Jarrison Plinallan*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *London Park* DATE OF BURIAL *Aug 3, 1915*

UNDERTAKER *William Book* ADDRESS *52 E North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2416 N. Charles St.* ST: *12* WARD)

2-FULL NAME *Allen Reynolds*

(Residence in Baltimore: No. *2416 N. Charles St.*

REGISTERED NO. C *79*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., *45* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*

4-COLOR OR RACE, *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)

6-DATE OF BIRTH, *April 21, 1870*

(Month)

(Day)

(Year)

7-AGE, *25* yrs., *3* mos., *11* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *House work*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Rhode Island*

10-NAME OF FATHER, *John Reynolds*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. Eugene Blair*

(Address) *2416 N. Charles St.*

15-AUG 3 - 1915

Filed..... 191

ROBERT KRAUTH

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 2, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* and that said deceased came to *death* (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *Harry G. Reynolds, M. D.*

Aug 2, 1915 (Address) *600 N. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL, *Aug 4, 1915*

20-UNDERTAKER

William Cook

ADDRESS *502 E North ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *2026 E. Chase*)

2-FULL NAME *Catherine Schoelen*

(Residence in Baltimore: No. *2026 E. Chase*)

ST: *8*

WARD

St: *60* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow* (Write the word)

6-DATE OF BIRTH *July 10th*, 1833 (Month) (Day) (Year)

7-AGE *82* yrs. *21* mos. ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession, or particular kind of work *House Keeping* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Manchester England*

10-NAME OF FATHER *Patrick M. Connell*

11-BIRTHPLACE OF FATHER (State or country) *England*

12-MAIDEN NAME OF MOTHER *Mary Hall*

13-BIRTHPLACE OF MOTHER (State or country) *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Geo. M. Padgett*

(Address) *2026 E. Chase St*

15-AUG 3 - 1915

ROBERT KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August 1*, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *May 1*, 1915, to *August 1*, 1915, that I saw her alive on *August 1*, 1915, and that death occurred, on the date stated above, at *8 P.* m. The CAUSE OF DEATH* was as follows:

Infirmities of old age and Congestion of Kidneys and Coma (Duration) *2* yrs. *3* mos. ds. Contributory (SECONDARY) (Signed) *J. J. Simon* M. D. (Address) *1025 N. Wolfe St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *London Park* DATE OF BURIAL *Aug. 5, 1915*

20-ADDRESS *1441 N. Brady*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 S Chapel ST.; 2 WARD)

REGISTERED NO. C

2-FULL NAME

August Kiesel

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 19 S ChapelSt.; 68 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,WIDOWED,OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

April 9, 1838
(Month) (Day) (Year)

7-AGE,

77 yrs., 3 mos., 26 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer).

Coat maker.

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

August Kiesel

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Not known.

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

John L. Kiesel

(Address),

19 S. Chapel St.

15-

AUG 3 - 1915

Filed.....

191

ROBERT . KRAUTERSuppl. Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 30, 1915, to August 2, 1915,that I saw him alive on Aug 1, 1915,and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)

Cerebral Apoplexy(Signed) Geo. Heller M. D.S. 3, 1915 (Address) 19 S. Chapel St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer Cent Aug 5, 1915

20-UNDERTAKER

ADDRESS

Robt. J. Turner 1412 N. Brady

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7* WARD)

2-FULL NAME *Evelyn B. Clark*

(Residence in Baltimore: No. *Johns Hopkins Hosp.* St. *7* yrs. *6* mos. *6* ds.)

REGISTERED NO. C. *087189*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *November 29, 1881*
(Month) (Day) (Year)

7-AGE *33* yrs. *6* mos. *6* ds. or *1* day, *0* hrs. *5* min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country) *Jamaica*

10-NAME OF FATHER *Chas. Hendricks*

11-BIRTHPLACE OF FATHER *Jamaica*
(State or country)

12-MAIDEN NAME OF MOTHER *Agnes P. Fair*

13-BIRTHPLACE OF MOTHER *Jamaica*
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. J. Smith*

(Address) *Johns Hopkins Hosp.*

AUG 3 - 1915 ROBERT . KRAUTER
FILED *191* SERIAL *10001* CLERK
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August 3, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 28, 1915*, to *Aug 3, 1915*, that I saw her alive on *August 2nd, 1915*, and that death occurred, on the date stated above, at *1:05* a.m.

The CAUSE OF DEATH* was as follows:

Cerebellar - pontine (Brain) tumor - (not tuberculous) Endothelioma

Contributory (SECONDARY) *Operation*
(Duration) *6* yrs. *6* mos. *6* ds.

(Signed) *George R. Owen* M. D.
Aug 3, 1915 [Address] *Johns Hopkins Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death *6* yrs. *6* mos. *6* ds. In the State *4* yrs. *6* mos. *6* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Kingston Jamaica*

19-PLACE OF BURIAL OR REMOVAL *Kingston Jamaica*

DATE OF BURIAL *Aug 3, 1915*

20-UNDERTAKER *Alfred C. Fuller*

ADDRESS *221 N. Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1931 Christian* ST. *20* WARD)

2-FULL NAME

Clarence Woodfield(Residence in Baltimore: No. *1931 Christian* St.; *13* yrs., *1* mos. *27* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

June 4th, 1902
(Month) (Day) (Year)

7-AGE,

13 yrs., *1* mos., *27* ds.

If LESS than 1 day,

...hrs. or...mins.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

George Warfield

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Georgia H. Goodhand

13-BIRTHPLACE OF MOTHER (State or Country)

Queen Anne Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

George Warfield

(Address)

1931 Christian St.

15-

*AUG 3 - 1915*Filed. *191**Burial Permit OK*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 1, 1915, to *Aug 1, 1915*,that I saw him alive on *Aug 1, 1915*,and that death occurred, on the date stated above, at *5:20 P.M.*

The CAUSE OF DEATH* was as follows:

Phemic Fever

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *F. N. Gammal* M. D.*Aug 2, 1915* (Address) *317 N. Carroll St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds. State ...

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Western Cemetery**Aug 3rd, 1915*

20-UNDERTAKER

W. B. Brothers

ADDRESS

27 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C. 104

CITY OF BALTIMORE: (No. 87191)

ST.

WARD 7

2-FULL NAME

Julius Hopkins Hopk

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

(Residence in Baltimore: No. 533 N. Bond St.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

July 3, 1915

(Month)

(Day)

(Year)

7-AGE

4 weeks

If LESS than

1 day, hrs.,

yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE

(State or country)

md.

10-NAME OF FATHER

Lester Jackson

11-BIRTHPLACE OF FATHER
(State or country)

md.

12-MAIDEN NAME OF MOTHER

Eleanor Jackson

13-BIRTHPLACE OF MOTHER
(State or country)

md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. Phelps

(Address)

John Hopkins Hosp

15-

AUG 3 - 1915

ROBERT JOHNS

JOHNS

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 1, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 30, 1915, to, Aug 1, 1915,

that I saw him alive on Aug 1, 1915,

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(Duration) yrs. mos. ds. 9

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed), A. S. Rotholz M. D.

Aug 1, 1915. [Address] John Hopkins Hosp

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. 2, In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 533 N. Bond St.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

AUG 2 1915

20-UNDERTAKER

ADDRESS

Baltimore Health

FOR ANATOMICAL PURPOSES.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-MARRIED

Married

(Write the word)

6-DATE OF BIRTH

December

1876

(Month)

(Day)

(Year)

7-AGE

78

yrs.

8

mos.

ds.

If LESS than

1 day, hrs.

or min. ?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

do

9-BIRTHPLACE

(State or country)

Carroll County, Md.

10-NAME OF FATHER

George Dicus

11-BIRTHPLACE OF FATHER

(State or country)

Carroll Co Md

12-MAIDEN NAME OF MOTHER

Fannie Forsett

13-BIRTHPLACE OF MOTHER

(State or country)

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John H. Dicus Jr

(Address)

1113 Park Ave

15-

AUG 3 - 1915

ROBERT

KRAUTER

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July

31

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 19, 1915, to July 31, 1915.

that I saw him alive on July 31, 1915.

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(Duration)

2 yrs.

mos.

ds.

Contributory

(SECONDARY)

Cerebral hemorrhage

(Duration)

1

mos.

ds.

(Signed)

Edwin R. Ballard M. D.

Aug 2, 1915

(Address)

1622 Mt Royal Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Laurel

DATE OF BURIAL

August 3, 1915

20-UNDERTAKER

R. Halliott

ADDRESS

506 Rogers Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *135 W Hill* ST. *22* WARD)2-FULL NAME *Florence C. Chany*(Residence in Baltimore: No. *135 W. Hill* St. *Life* yrs. *Life* mos. *Life* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *June 26, 1893*7-AGE, *22* yrs. *1* mos. *8* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Domestic*(b) General nature of industry, business, or establishment in which employed (or employer), *Private Family*9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Horace Chany*11-BIRTHPLACE OF FATHER, (State or Country), *Md*12-MAIDEN NAME OF MOTHER, *Mary Johnson*13-BIRTHPLACE OF MOTHER, (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Chany*(Address) *135 W. Hill*

15-

AUG 3 - 1915

ROBERT . KRAUTER

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 3, 1915*17- I HEREBY CERTIFY, That I attended deceased from *July 25, 1915*, to *Aug 3, 1915*, that I saw her alive on *Aug 2, 1915*, and that death occurred, on the date stated above, at *20* m.

The CAUSE OF DEATH* was as follows:

Tuberculosis(Duration) yrs. mos. *8* ds.CONTRIBUTORY (Secondary) *Stomach*(Duration) yrs. mos. *8* ds.(Signed) *Chas. H. Hays* M. D.*Aug 3, 1915* (Address) *712 S. 8th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt Auburn Ct*DATE OF BURIAL, *Aug 4, 1915*20-UNDERTAKER, *J. H. Brown & Son*ADDRESS, *108 N. Montz*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE; (No. *University Hospital* ST. *17* WARD)2-FULL NAME *Edna E. Mitchell*(Residence in Baltimore: No. *732 West Mulberry* St.; yrs. *8* mos. *8* ds.)REGISTERED NO. C. *108*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Negro

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

December 25, 1885
(Month) (Day) (Year)

7-AGE,

29 yrs. *8* mos. *8* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*House wife*9-BIRTHPLACE,
(State or Country),*Virginia*

10-NAME OF FATHER,

*John Maly*11-BIRTHPLACE OF FATHER
(State or Country),*Virginia*

12-MAIDEN NAME OF MOTHER

*Emma Davis*13-BIRTHPLACE OF MOTHER
(State or Country),*Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Julian D. Mitchell

(Address)

732 W. Mulberry St.

AUG 3 - 1915.

ROBERT J. KRAUSE

Burial Permit Officer

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 1, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 31 - 1915*, to *August 1 - 1915*, that I saw her alive on *August 1* 1915, and that death occurred, on the date stated above, at *9 P* m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis with Post Cecal Abscess
(Duration) *Unknown* yrs. *Unknown* mos. *Unknown* ds.

CONTRIBUTORY

(Secondary)

Peritonitis with Ruptured Appendix
(Duration) *Unknown* yrs. *Unknown* mos. *Unknown* ds.

(Signed)

R. L. Johnson M. D.
8/1, 1915 (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. *2* ds. In the State yrs. *8* mos. *8* ds.

Where was disease contracted, if not at place of death?

Unknown

Former or usual residence

732 West Mulberry St.

19-PLACE OF BURIAL OR REMOVAL,

St. Auburn Cem.

DATE OF BURIAL,

Aug 4, 1915

20-UNDERTAKER

George H. Holland

ADDRESS

517 Robert St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2434 Madison Ave ST. 13 WARD) REGISTERED NO. C
2-FULL NAME George Morrow - (George Monon)
(Residence in Baltimore: No. 2434 Madison Ave St.; 40 yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
6-DATE OF BIRTH, July 23, 1853
7-AGE, 62 yrs. — 9 mos. — 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Editor
(b) General nature of industry, business, or establishment in which employed (or employer), Baltimore Sun

9-BIRTHPLACE, (State or Country), Washington Co., Md.

10-NAME OF FATHER, Not Known
11-BIRTHPLACE OF FATHER (State or Country), Not Known
12-MAIDEN NAME OF MOTHER, Mary A. Cline
13-BIRTHPLACE OF MOTHER (State or Country), Washington Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Amelia H. Morrow
(Address), 2434 Madison Ave

15- AUG 3 - 1915. HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 2, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 21, 1915, to Aug 2, 1915, that I saw him alive on Aug 2, 1915, and that death occurred, on the date stated above, at 3 a m. The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Aneurysm
(Duration) yrs. mos. ds.
(Signed) Thos. J. Gibney M. D.
Aug 3, 1915 (Address) 622 N. Howard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount DATE OF BURIAL, Aug. 4, 1915.

20-UNDERTAKER, Geo. W. Little ADDRESS, 531 N. Fremont Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87196

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

C87196

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *229 Courtland* ST. *4* WARD)

2-FULL NAME *Elizabeth Graninger*

(Residence in Baltimore: No. *229 Courtland* St.; *70* yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

white

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widow

6-DATE OF BIRTH

March 28, 1883
(Month) (Day) (Year)

7-AGE

83 yrs. *4* mos. *6* ds. or min. If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Germany

PARENTS

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER
(State or country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mary C. Henkens*

(Address) *229 Courtland St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 3, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 30, 1915*, to, *Aug 3, 1915*, that I saw her alive on *Aug 2, 1915*, and that death occurred, on the date stated above, at *4 A. M.* The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. *1 day*
Contributory (SECONDARY) *Paralysis*

(Signed) *Frank Whymor* M. D.
Aug 3, 1915 [Address] *322 N. Green St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Aug 4, 1915

20-UNDERTAKER

ADDRESS *1844 F St.*

Harry H. Allen

W. Hall

AUG 3 - 1915.

Filed 191

HARRY O. ANDREWS,

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87197

HEALTH DEPARTMENT—CITY OF BALTIMORE

87197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Filed

AUG 3 - 1915

Regist. Mortal Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an... (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said... (Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

(Coroner) ... (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; 49 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

AUG. 3 - 1915

HARRY O. ANDREWS,

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17. I HEREBY CERTIFY, That I attended deceased from September 30th 1914, to Aug. 3rd, 1915, that I saw h.v. alive on Aug. 2nd, 1915, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *8*)

2-FULL NAME

(Residence in Baltimore: No. *Boys Home (Calverton Place St. 1)*)ST.: *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

*About**November 1*

7-AGE,

18

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Drug Store
*Heggers*9-BIRTHPLACE,
(State or Country),*Don't know*
Baltimore

10-NAME OF FATHER,

*Don't know*11-BIRTHPLACE OF FATHER
(State or Country)*Don't know*

12-MAIDEN NAME OF MOTHER

*Don't know*13-BIRTHPLACE OF MOTHER
(State or Country)*Don't know*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. H. J. Wilson, Rept.

(Address)

Boys Home

15-AUG 3 - 1915.

HARRY O. ANDREWS,

Filed..... 191.....

Bartol. Permit. 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August

(Month)

2nd

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 17th* 1915, to *Aug 2nd* 1915, that I saw him alive on *Aug 2nd* 1915, and that death occurred, on the date stated above, at *5:05 P.M.*

The CAUSE OF DEATH* was as follows:

Pernicious Anemia(Duration)..... yrs. *2* mos. *?* ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... *H. E. Shipley*..... M. D.*Aug 2nd* 1915 (Address)..... *Boys Home*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. *2* mos. *16* ds. In the *18* State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Woodward Hospital

19-PLACE OF BURIAL OR REMOVAL,

Louder Park

DATE OF BURIAL,

Aug. 4, 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87200

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 C87200
REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Dallas St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and IN out No. 12.)

2-FULL NAME Clarissa Hooker

(Residence in Baltimore: No. 517 N. Dallas St. 55 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE Caucasian 5-SINGLE Married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH Unknown, 1848
(Month) (Day) (Year)

7-AGE 67 yrs. — mos. — ds. or min. 7 If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Private Family

9-BIRTHPLACE (State or country) Ind

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Unknown

12-MAIDEN NAME OF MOTHER Johnson

13-BIRTHPLACE OF MOTHER (State or country) Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. H. Hooker
(Address) 517 N. Dallas St

AUG 3 - 1915.

Filed....., 191

HARRY O. ANDREWS,
Bureau of Health, CLERK,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 31 - 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 28 - 1915 to July 31 - 1915, that I saw her alive on July 31 - 1915, and that death occurred, on the date stated above, at 11/45 P.M.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Contributory (SECONDARY) Chronic Nephritis (Duration) 3 yrs. — mos. — ds.
9 yrs. — mos. — ds.
(Signed) H. H. Hooker M. D.
Aug 3 - 1915 [Address] 1716 Jefferson St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs. — mos. — ds. In the State..... yrs. — mos. — ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Abney Cemetery Aug 4th 1915
2-UNDERTAKER ADDRESS
Chas E Bailey 1421
Jefferson St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087201		HEALTH DEPARTMENT--CITY OF BALTIMORE		81 087201	
PLACE OF DEATH		CERTIFICATE OF DEATH		REGISTERED No. C	
CITY OF BALTIMORE (No. <i>1820 Etting</i>)		ST. <i>14</i> WARD)		(If death occurred in a hospital or institution, give its NAME instead of street and number and FBI out No. 18.)	
2-FULL NAME <i>Richard Brady</i>		Str. <i>2</i> yrs. mos. ds.)			
(Residence in Baltimore: No. <i>1820 Etting</i>)					
PERSONAL AND STATISTICAL PARTICULARS					
3-SEX <i>Male</i>	4-COLOR OR RACE <i>White</i>	5-SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Widowed</i> (Write the word)			
6-DATE OF BIRTH <i>Unknown</i> , 1820 (Month) (Day) (Year)					
7-AGE <i>95</i> yrs. mos. ds. or less than 1 day, hrs. min.?					
8-OCCUPATION (a) Trade, profession, or particular kind of work <i>Farmer</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>Retired</i>					
9-BIRTHPLACE (State or country) <i>Anne Arundel Co. Md</i>					
PARENTS	10-NAME OF FATHER <i>Unknown</i>				
	11-BIRTHPLACE OF FATHER (State or country) <i>Unknown</i>				
	12-MAIDEN NAME OF MOTHER <i>Unknown</i>				
	13-BIRTHPLACE OF MOTHER (State or country) <i>Unknown</i>				
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Mathew Harrison</i> (Address) <i>1820 Etting St</i>					
AUG 3 - 1915. HARRY O. ANDREWS, Registrar					
MEDICAL CERTIFICATE OF DEATH					
16-DATE OF DEATH <i>Aug 2</i> , 1915 (Month) (Day) (Year)					
I HEREBY CERTIFY, That I attended deceased from <i>June 15</i> , 1915, to <i>Aug 2</i> , 1915, that I saw him alive on <i>Aug 2</i> , 1915, and that death occurred, on the date stated above, at <i>6:15</i> p.m. The CAUSE OF DEATH* was as follows: <i>Heart & Arterio Sclerosis</i> (Duration) yrs. mos. ds. <i>40</i>					
Contributory (SECONDARY) <i>General Debility</i> (Duration) yrs. mos. ds. <i>10</i>					
(Signed) <i>J. A. Melune</i> M.D. <i>Aug 3</i> , 1915 (Address) <i>1303 W. North St</i>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence					
19-PLACE OF BURIAL OR REMOVAL <i>Marley A. A. Co. Ind.</i> DATE OF BURIAL <i>Aug 4</i> , 1915					
20-UNDERTAKER <i>George H. Holland</i> ADDRESS <i>517 Robert St</i>					

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Skin and Cancer Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

250 W 21st St

ST.; 12 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and all opt No. 18.)

2-FULL NAME

David Liebman

(Residence in Baltimore: No.

Skin and Cancer Hospital

St.;

4th mo. 1915

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH.

July 27th, 1857

7-AGE

58

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Tobacco merchant

9-BIRTHPLACE, (State or Country).

Balt.

10-NAME OF FATHER,

Jos Liebman

11-BIRTHPLACE OF FATHER (State or Country).

Germany.

12-MAIDEN NAME OF MOTHER

Rachel Seligman

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Henry Liebman

(Address)

4706 Garrison Ave

15-AUG 3 - 1915

HARRY O. ANDREWS,

Filed..... 1915

Serial Permit 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 2nd

(Month)

(Day)

1915

17- I HEREBY CERTIFY, That I attended deceased from

March 14 1915, to Aug 2 1915,

that I saw him alive on Aug 1st 1915,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder
Metastases to Lungs, Liver, Bones
T. Rx. by Dr. Charles C. Coppy, M.D.
(Duration)..... yrs. 1st mo. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mo. 10 ds.

(Signed).....

Geo. H. Everhart

M. D.

Aug 2, 1915. (Address) 150 W. 21st St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 4 mo. 19 ds. In the State 58 yrs. 7 mo. 6 ds.

Where was disease contracted, if not at place of death? 4706 Garrison Ave

Former or usual residence 4706 Garrison Ave

19-PLACE OF BURIAL OR REMOVAL,

Har Sinai Cem

DATE OF BURIAL,

8/4, 1915

20-UNDERTAKER

David Sondheim 118 W. 1st Royal Ave

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

087203

CERTIFICATE OF DEATH

79

087203

1 PLACE OF DEATH

Presbyterian Home
for Women
822 N. Carrollton St.

REGISTERED NO. C

CITY OF BALTIMORE (No.

822 N. Carrollton St.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2 FULL NAME

Susan Watts

(Residence in Baltimore: No.

Presbyterian Home for Women

St.: 1 yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widow

6 DATE OF BIRTH

June 16th, 1828

7 AGE

87 yrs. 1 mos. 17 ds.

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Inmate (none)

9 BIRTHPLACE
(State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER
(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. A. Watts

(Address)

1403 Mt Royal Ave

15

AUG 3 - 1915

HARRY O. ANDREWS,

Filed

, 191

Special Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 2, 1915

17. I HEREBY CERTIFY. That I attended deceased from October 1, 1913, to August 2, 1915.

that I saw her alive on August 2, 1915, and that death occurred, on the date stated above, at 5 p. m. The CAUSE OF DEATH* was as follows:

Organic heart disease
(Coronary sclerosis)

(Duration) 1 yrs. 10 mos. 2 ds

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) H. M. Stevenson, M. D.
August 3, 1915 (Address) 1022 West 11th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 10 yrs. 2 mos. 2 ds. In the Life

Where disease contracted, Presbyterian Home for Women

If not at place of death?

Former or usual residence Presbyterian Home for Women

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Southern Park cemetery

Aug 4th, 1915

20 UNDERTAKER

ADDRESS

W. M. Underwood 1616 Chase St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *612 S. Washington* ST.; *2* WARD)

2-FULL NAME

Mary Nowak(Residence in Baltimore: No. *612 S. Washington* St.; *26* yrs., *—* mos., *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *Jan. 8, 1869*
(Month) (Day) (Year)

7-AGE, *46 yrs. 3 mos. 25 ds.* If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer) *At Home*

9-BIRTHPLACE,
(State or Country),*Germany*

PARENTS.

10-NAME OF FATHER,

*John Janikowski*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Michalina Dobrosielska*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Marcin Nowak

(Address)

612 S. Washington

15-

AUG 4 - 1915

Filed

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 5, 1915*, to *August 1, 1915*, that I saw her alive on *August 1, 1915*, and that death occurred, on the date stated above, at *10 A. M.* The CAUSE OF DEATH* was as follows:

Coronary Sclerosis
(Chronic) (Longstanding)(Duration) *2* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Asthma*(Duration) *3* yrs. mos. ds.(Signed) *Harry D. Rutledge* M. D.*Aug 1, 1915* (Address) *106 Jackson St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Aug 4, 1915

20-UNDERTAKER

William Fialkowski

ADDRESS

1618 Eastern Ave

N.B.—Every item of information should be carefully supplied. AGE, MONTH OF BIRTH, PLACE OF BIRTH, PLACE OF DEATH, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087205 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. 22 WARD)

St. 50 yrs. mos. ds.)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Unknown, 1862

7 AGE

53

Yrs. mos. ds. or min.?

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Librarian
General

9 BIRTHPLACE (State or country)

Charles Town, Md.

10 NAME OF FATHER

James Jones

11 BIRTHPLACE OF FATHER (State or country)

Charles Town

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Charles Town

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

AUG 4 - 1915

Filed

191

Chas M. Sinclair

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 1, 1915

17 I HEREBY CERTIFY, That I attended deceased from

Jan 2, 1915, to, Aug 1, 1915.

that I saw him alive on Aug 1, 1915.

and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Contributed to death)

Contributory (SECONDARY)

Heart Failure

(Signed),

Charles H. Jones, M. D.

Aug 2, 1915 (Address) 712 S. Sharp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Angel Grove

Aug 5, 1915

20 UNDERTAKER

ADDRESS

Wm. H. Chas. H. Jones

1400 Woodstock

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087206 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 087206
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 2nd Carrollton av. 16 ST. 16 WARD)

2-FULL NAME *Amelia F. Williams*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 100 2nd Carrollton av. St. 16 yrs. 3 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *F* 4-COLOR OR RACE *C* 5-SINGLE *Widowed*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Amherst 1861*
(Month) (Day) (Year)

7-AGE *54* yrs. *1* mos. *1* day, *1* hrs. *1* min.?
If LESS than 1 day, hrs. min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
Housework

9-BIRTHPLACE (State or country)
Maryland

10-NAME OF FATHER *Amos Whittington*

11-BIRTHPLACE OF FATHER (State or country)
Maryland

12-MAIDEN NAME OF MOTHER
Unknown

13-BIRTHPLACE OF MOTHER (State or country)
Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Oscar Williams*

(Address) *100 2nd Carrollton av.*

15-

Filed *AUG 4 - 1915* *Chas. M. Muelcke*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *Aug. 2, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 2, 1915*, to, *Aug 2, 1915*, that I saw her alive on *Aug 2, 1915*, and that death occurred, on the date stated above, at *2:40 P. m.*
The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) *6* yrs. *6* mos. *0* ds.
Contributory (SECONDARY) *Arterio Sclerosis*
(Duration) *unknown* yrs. *0* mos. *0* ds.
(Signed) *J. H. Meyer* M.D.
Aug. 3, 1915 [Address] *1209 Broad St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *0* yrs. *0* mos. *0* ds. In the *0* yrs. *0* mos. *0* ds. State

Where was disease contracted, if not at place of death?

Former or usual residence

16-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marion Street *Aug 4, 1915*
Summers Co. Md.

19-UNDERTAKER ADDRESS

Sam. W. Chase & Son *400 N. Mosher*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 Pleasant St., 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas J. Lyons (Lyons)

(Residence in Baltimore: No. 102 Pleasant St.; 56 yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, not known, 1 (Month) (Day) (Year)

7-AGE, about 56 yrs., — mos., — da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Miller (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto - Md.

PARENTS.	10-NAME OF FATHER, Not known
	11-BIRTHPLACE OF FATHER (State or Country), Not known
	12-MAIDEN NAME OF MOTHER, Not known
	13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas J. Lyons Jr.

(Address) 102 Pleasant St.

15-

Filed AUG 4 1915 1915 Chas. M. Mulvey Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 3rd, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1915, to Aug 3 1915, that I saw him alive on Aug 3rd 1915, and that death occurred, on the date stated above, at 10:30 pm.

The CAUSE OF DEATH* was as follows:

Heart Stroke (Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Syncope 1/4 hr.

(Signed) J. D. Sauer M. D. Aug 4 1915 (Address) 219 E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery DATE OF BURIAL, Aug 6 1915

20-UNDERTAKER, Henry Storch Son ADDRESS, 1301 E. Sigsbee

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 W. North Avenue ST. 13 WARD)

REGISTERED NO. C

2-FULL NAME

Babbette Sondheim

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1208 W. North AvenueSt. 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July 20, 1840
(Month) (Day) (Year)

7-AGE, 75 yrs., 14 mos., ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Germany

PARENTS.

10-NAME OF FATHER, Benjamin Gutman11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin Sondheim(Address) 1208 W. North Ave.

15-

AUG. 4, 1915Chas. M. Swelart
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 3rd, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1915, to Aug. 3rd 1915, that I saw h e alive on August 3rd 1915, and that death occurred, on the date stated above, at 8 A. m. The CAUSE OF DEATH* was as follows:

Coronary Stenosis & Myocarditis(Duration) 5 yrs., mos., ds.

CONTRIBUTORY (Secondary)

Pulmonary Edema(Duration) 1 yr., mos., ds.

(Signed)

Michael S. Abrams

M. D.

Aug. 4, 1915 (Address) 1634 E. Balto. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Balto. Hebrew Cem.8/5, 1915

20-UNDERTAKER

ADDRESS

David Sondheim118 W. Mt. Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87209

CERTIFICATE OF DEATH.

167 C87209

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Woodall ST.; 24 WARD)

2-FULL NAME

Adolph Pomerence

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1428 Woodall St.; 1 yrs., 7 mos., 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Dec41913

(Month)

(Day)

(Year)

7-AGE,

1 yrs., 7 mos., 29 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which

employed (or employer).

child

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Theodor Pomerence

11-BIRTHPLACE

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Bertha Pomerence

13-BIRTHPLACE

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Theodor Pomerence

(Address).

1428 Woodall St.

15-

Filed.

AUG 4 - 1915

191.

Chas. M. Swelley

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug241915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 25 1915, to Aug 15 1915,that I saw him alive on Aug 1 1915,and that death occurred, on the day stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Burns
Accident - Fell into a kettle of
boiling starch (Duration) 14 mos., 14 ds.

CONTRIBUTORY

(Secondary)

(Duration) 4 yrs., 4 mos., 4 ds.(Signed) W. H. Hayden M. D.Aug 24, 1915 (Address) Aug 24, 1428 Woodall St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs., 7 mos., 29 ds. In the State 1 yrs., 7 mos., 29 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill CemAug 4, 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E North or

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1744 E Madison ST., 7 WARD)

2-FULL NAME

Gordon Clinton Howes(Residence in Baltimore: No. 1744 E Madison St.: yrs., 9 mos. 19 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH.

Oct 14, 1914
(Month) (Day) (Year)

7-AGE.

9 yrs., 19 mos., 19 ds.If LESS than 1 day,
hrs. or mins.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business,
or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country).Balto City10-NAME OF
FATHER.B. Herbert Howes11-BIRTHPLACE
OF FATHER
(State or Country).Md.12-MAIDEN NAME
OF MOTHERElsie C Burns13-BIRTHPLACE
OF MOTHER
(State or Country).Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. Herbert Howes(Address) 1744 E Madison

15-

Filed..... 1915

Chas. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 2, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Aug 2, 1915, to Aug 2, 1915,
that I saw him alive on " " 1915,
and that death occurred, on the date stated above, at 11⁰⁰ pm.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration).....15 hrs.....15 mos.....15 ds.CONTRIBUTORY
(Secondary)(Duration).....15 hrs.....15 mos.....15 ds.
(Signed) George J. Mathews M. D.
Aug 2, 1915 (Address) 1744 E Madison*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

20-UNDERTAKER

Alfred E. Fuller

DATE OF BURIAL,

Aug 5, 1915

ADDRESS

221 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No

St.;

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

16-

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on
and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Latent Sinus Thrombosis
Chronic Mastoiditis, Chronic Sinusitis,

Contributory
(SECONDARY)

(Signed),

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. 27 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87212

CERTIFICATE OF DEATH

26 87212
REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 Hanover St. 23 WARD)

2-FULL NAME Charlotte M. Jones

(Residence in Baltimore: No. 1714 Hanover St. 6 yrs. 6 mos. 6 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX F.

4-COLOR OR RACE W.

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH June 9, 1909

7-AGE 6 yrs. 1 mos. 24 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore

10-NAME OF FATHER Harry M. Jones

11-BIRTHPLACE OF FATHER (State or country) Mass.

12-MAIDEN NAME OF MOTHER Annie Pinkard

13-BIRTHPLACE OF MOTHER (State or country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry M. Jones

(Address) 1714 Hanover St.

15- AUG 4 - 1915

Filed

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Charles M. Suddas REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug. 3, 1915

17- I HEREBY CERTIFY, That I attended deceased from June 24, 1915, to Aug 3, 1915, that I saw her alive on Aug 3, 1915, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(Duration) 2 yrs. 6 mos. 6 ds.

Contributory (SECONDARY)

(Duration) 2 yrs. 6 mos. 6 ds.

(Signed) J. L. Hirsch M. D.

Aug 3, 1915 [Address] 1819 Linden

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rest. St. Mt. Aug 5, 1915

20-UNDERTAKER

ADDRESS

W. J. Jones 14401 Bnd

C87213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

2. CITY OF BALTIMORE: (No. 646 George

3. FULL NAME George W Scott

(Residence in Baltimore: No. 646 George St

ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Unknown, 1845

(Month)

(Day)

(Year)

7-AGE,

70

If LESS than 1 day.

yrs.

mos.

ds.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE, (State or Country),

Harford Co Maryland

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country).

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Hannabell

(Address)

646 George St

15-

AUG 4 - 1915

Charles N. Huelar

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 1st, 1915.

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

July 30th 1915, to Aug 1st 1915,

that I saw him alive on Aug 1st 1915,

and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) yrs. mos. ds.

(Signed) D. Grantfoot M. D.

Aug 2, 1915 (Address) 125 W. Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

Aug 1st 1915

20-UNDERTAKER

Sam'l T. Hensley

ADDRESS

578 W. Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87211

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

29C87211

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16)

2-FULL NAME

(Residence in Baltimore: No. 1022)

John Hopkins Hospital
Alonso Carroll
1022 Carey Street

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

Unknown, 1915
(Month) (Day) (Year)

7-AGE

If LESS than
1 day, hrs.,
yrs. 9 mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Maryland?

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER
(State or country)

"

12-MAIDEN NAME OF MOTHER

Carroll

13-BIRTHPLACE OF MOTHER
(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

P. Roszel
Johns Hopkins Hospital

15-

Filed

AUG 4 - 1915

1915

Johns Hopkins Hospital
Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 31, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 26th, 1915, to July 31st, 1915,
that I saw him alive on July 31st, 1915,
and that death occurred, on the date stated above, at 5:28 p.m.

The CAUSE OF DEATH* was as follows:

General
Military Tuberculosis

(Duration) yrs. 2 mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed), John F. Powers

July 31st, 1915 (Address) Johns Hopkins Hospital

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. 5 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

1022 Carey Street

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

AUG 3 1915

20-UNDERTAKER

ADDRESS

Announcement

FOR ANATOMICAL PURPOSES

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87215

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *4* WARD)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Windsor Hills* md. St. *40* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH.

Not known
(Month) (Day) (Year)

7-AGE.

abt. 65

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

England

10-NAME OF FATHER.

Not known

11-BIRTHPLACE OF FATHER (State or Country).

Not known

12-MAIDEN NAME OF MOTHER

Kate C. Moore

13-BIRTHPLACE OF MOTHER (State or Country).

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mercy Hosp

(Address)

Calvert St.

15-

Filed

AUG 4 - 1915

Chas M. Sevelay

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 4, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 3* 191*5*, to *Aug 4* 191*5*, that I saw her alive on *Aug 4* 191*5*, and that death occurred, on the date stated above, at *5:00 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum
Operation (Colostomy) Aug 3-15
along (Duration) *1* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

Intestinal Obstruction
(Duration) *1* yrs. *1* mos. *1* ds.(Signed) *Edward P. Smith* M. D.*Aug 4*, 191*5*. (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *1* ds. In the *Don't know* State *1* yrs. *1* mos. *1* ds.Where was disease contracted, if not at place of death? *Windsor Hills md.*Former or usual residence *Windsor Hills md.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

New Cathedral C. *Aug 6*, 191*5*

20-UNDERTAKER

ADDRESS

Edw Mitchell *2401 N. E. Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Howard A Kelly Hosp. 15*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *3031 W. North Ave.* St.; *63* yrs., *9* mos., *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *widowed*

6-DATE OF BIRTH,

Nov. 28, 18*51*
(Month) (Day) (Year)

7-AGE,

63 yrs., *9* mos., *6* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Salesclerk*
*Dept. Store*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*Thom. C. James*11-BIRTHPLACE OF FATHER
(State or Country),*Balto.*

12-MAIDEN NAME OF MOTHER

*Marg. Jones*13-BIRTHPLACE OF MOTHER
(State or Country),*Wales*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wick Marg. E. James*(Address) *3031 W. North Ave.*

15-

*AUG 4 - 1915**Chas M. Sinclair*

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug, *2*, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 25* 191*5*, to *August 2* 191*5*, that I saw her alive on *Aug 2* 191*5*, and that death occurred, on the date stated above, at *10:55* a.m.

The CAUSE OF DEATH* was as follows:

*Pulmonary embolism**Duration June 20 1915**at home**CONTRIBUTORY* *Woman & child**(Secondary)* *Several years**(Duration)* *1 yrs.**(Signed)* *W. E. Smith* M. D.*Aug 2*, 191*5*. (Address) *1418 E. East Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. *1* mos. *8* ds. In the *63* yrs., *9* mos., *6* ds. StateWhere was disease contracted, *3031 W. North Ave. Balto.*
if not at place of death?Former or usual residence *3031 W. North Ave., Balto.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Green Mount *Aug 4*, 191*5*

20-UNDERTAKER

Em. Mitchell *1401 W. Fayette*

N. B.—Every item of information should be carefully supplied. Age should be stated in years, months, and days. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CS7218 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 910 N. Payson street, ST.: 16 WARD)

2-FULL NAME John D. Lederer,

(Residence in Baltimore: No. 910 N. Payson street,

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married, (Write the word.)

6-DATE OF BIRTH, December 18th, 1853. (Month) (Day) (Year)

7-AGE, 61 yrs., 7 mos., 15 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Barber, in (b) General nature of industry, business, or establishment in which employed (or employer), business for him-

9-BIRTHPLACE, self Baltimore, Md. (State or Country),

10-NAME OF FATHER, J. Conrad Lederer,

11-BIRTHPLACE OF FATHER, Germany, (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown,

13-BIRTHPLACE OF MOTHER, Unknown, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Lederer, wife,

(Address) 910 N. Payson street.

15- AUG 4 1915, 191. Charles M. Sunday Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 2nd, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy- probably due to Chronic interstitial nephritis.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Indefinite

(Signed) J. Frederick Campbell M. D. (Coroner.)

Aug. 2, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, London Park Cemetery Aug. 4th, 1915.

20-UNDERTAKER, ADDRESS, F.B. Huppert 2138 Fredk. av

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87219

CERTIFICATE OF DEATH

C87219

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 835 N. Fremont St. 17 WARD)

2-FULL NAME

George Mayhew Cook

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 835 N. Fremont Ave. St. yrs. mo. da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widower

6-DATE OF BIRTH

Sept

26, 1882

7-AGE

32

10 mos. 6

If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Machinist

9-BIRTHPLACE

(State or country)

Mary land.

10-NAME OF FATHER

George E. Cook

11-BIRTHPLACE OF FATHER

(State or country)

Md.

12-MAIDEN NAME OF MOTHER

Anneha Coleman

13-BIRTHPLACE OF MOTHER

(State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Cook

(Address)

835 N. Fremont Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug

1

1915

17-I HEREBY CERTIFY, That I attended deceased from

July 13

1915, to,

Aug 1

1915,

that I saw him alive on

Aug 1

1915,

and that death occurred, on the date stated above, at

7

m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation + valvular insufficiency.

about 4

Contributory (SECONDARY)

(Signed)

H. E. Kniff

Phys 2

1915

[Address]

100 N. Tanawah

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

Yrs. mos. ds.

In the State

Yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Louisa Park

DATE OF BURIAL

Aug 5, 1915

20-UNDERTAKER

Marin Ferguson

ADDRESS

606 Lafayette Ave

087220

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

145 087220
REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asy.* ST.: *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Andrew Richmond(Residence in Baltimore: No. *St. Vincent's Infant Asylum.* St.: yrs. mos. *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Montain About *July* *12th*, *1915*.
(Month) (Day) (Year)

7-AGE,

*About*yrs. *1* mos. ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*10-NAME OF
FATHER,*Unknown*11-BIRTHPLACE
OF FATHER
(State or Country),*Unknown*12-MAIDEN NAME
OF MOTHER*Unknown*13-BIRTHPLACE
OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division*

15-

AUG 4 - 1915

Filed

191

Chas. M. Suclaw

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug *12th*, *1915*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 13 1915, to *Aug. 12th* 1915,that I saw him alive on *Aug. 12th* 1915,and that death occurred, on the date stated above, at *2:30 P.M.*

The CAUSE OF DEATH* was as follows:

M. abruption(Duration) yrs. *1* mos. ds.CONTRIBUTORY *Chorea* *Contagiosa*
(Secondary)(Duration) yrs. mos. *14* ds.(Signed) *J. E. Poulton* M. D.*Aug. 2* A.D. (Address) *615 Columbia Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *18* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Cathedral Ave *Aug 5, 1915*

20-UNDERTAKER

ADDRESS

Martin T. Cahy & Sons *606 Lafayette Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf't Asy* ST.: *14* WARD)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs. *1* mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *May 23, 1915* (Month) (Day) (Year)

7-AGE, *2 mos. 11 ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

FILER

AUG 4 - 1915

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 3rd, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 2, 1915*, to *Aug. 2nd, 1915*, that I saw him alive on *Aug. 2nd, 1915*, and that death occurred, on the date stated above, at *6006* m. The CAUSE OF DEATH* was as follows:

Malnutrition and Malassimilation
(Duration) yrs. *1* mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *J. P. Sullivan* M. D.
Aug. 3, 1915 (Address) *615 Columbian Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. ds. In the State yrs. *2* mos. *11* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

Calhoun Ave
Martin Fabyan *606 Lafayette Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Vincent's Infirmary* ST.: *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St Vincent's Infirmary* St.; yrs. *3* mos. *25* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 9th, 1915
(Month) (Day) (Year)

7-AGE,

3 mos. 25 da.

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

Filed

AUG 4 - 1915

101

Chas. M. Suckow

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 3rd, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1st* 1915, to *Aug. 2nd* 1915, that I saw her alive on *Aug 2nd* 1915, and that death occurred, on the date stated above, at *2.00 p.m.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) yrs. *2* mos. *2* da.CONTRIBUTORY
(Secondary)*M. abscess*(Duration) yrs. *2* mos. *4* da.(Signed) *J. E. Roulton* M. D.*Aug. 3, 1915* (Address) *615 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *3* mos. *25* da. In the State yrs. *3* mos. *25* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral Cem.**Aug. 5, 1915*

20-UNDERTAKER

ADDRESS

*Marvin P. Hays**606 Lafayette*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asy.* ST. *14* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs., *2* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

April 30, 1915
(Month) (Day) (Year)

7-AGE,

3 mos. 2 ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

Filed

AUG 4 - 1915

191

Chas. M. Sudder

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 2nd, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1st* 1915, to *Aug 1st* 1915, that I saw him alive on *Aug 1st* 1915, and that death occurred, on the date stated above, at *2.00 p.m.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) yrs. mos. *2* ds.CONTRIBUTORY
(Secondary)*Tuberculosis*(Duration) yrs. mos. *14* ds.(Signed) *J. E. Brillon* M. D.*Aug 2, 1915.* (Address) *615 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. ds. In the State yrs. *3* mos. *2* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral Ave**Aug. 5, 1915*

20-UNDERTAKER

ADDRESS

*Martin L. Hershovs**606 Lafayette Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST. *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Margaret V. Cook(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. *1* mo. *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

June *5*, 1915.
(Month) (Day) (Year)

7-AGE.

yrs. *1* mo. *27* ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country).

Maryland

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER (State or Country).

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

AUG 4 - 1915

Filed

191

Chas M. Sullivan

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug *12*, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 12* 1915, to *Aug 12* 1915, that I saw her alive on *Aug 12* 1915, and that death occurred, on the date stated above, at *9.50 P. m.*

The CAUSE OF DEATH* was as follows:

Malnutrition(Duration) yrs. *1* mo. *27* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. *1* mo. *27* ds.(Signed) *W. B. Sullivan* M. D.*Aug 2nd* 1915. (Address) *615 Columbia*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mo. *12* ds. In the State yrs. *1* mo. *27* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Cathedral Cemetery**Aug 3, 1915*

20-UNDERTAKER

ADDRESS

*Martin Schuyler**606 E. Fayette Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87225
PLACE OF DEATH
CITY OF BALTIMORE: (No. *St. Vincent's Infant Asy.* ST.: *14* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
FULL NAME *Peter Traynor*
(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs., *2* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
6-DATE OF BIRTH, *June 2nd, 1915*
(Month) (Day) (Year)
7-AGE, yrs., *2* mos. ds. If LESS than 1 day. hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Maryland
Unknown

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*St. Vincent's*

(Address).....*1401 Division St.*

15-

AUG 4 - 1915

Filed

101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 2nd, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 1st* 1915, to *August 2nd* 1915, that I saw him alive on *August 2nd* 1915, and that death occurred, on the date stated above, at *1130 A. M.*

The CAUSE OF DEATH* was as follows:

Malnutrition and Mal-assimilation

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed).....*J. S. Sullivan* M. D.

Aug. 3, 1915 (Address) *615 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral

Aug 5, 1915

20-UNDERTAKER

ADDRESS

Martin T. Anyas

606 Lafayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *8*)

2-FULL NAME

(Residence in Baltimore: No. *8*)

REGISTERED NO. C

WARD) *8*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

*Aug 2**7**1915*

(Month)

(Day)

(Year)

7-AGE.

2

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country).*Md. (City)*

10-NAME OF FATHER.

*Jacob Crystal*11-BIRTHPLACE OF FATHER
(State or Country).*Russia*

12-MAIDEN NAME OF MOTHER

*Fannie Swartz*13-BIRTHPLACE OF MOTHER
(State or Country).*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alvin McClure*(Address) *Mercy Hospital*

15-

AUG 4 - 1915

HARRY O. ANDREWS,

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*Aug 4**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 2 191*5*, to *Aug 4* 191*5*,that I saw him alive on *Aug 4* 191*5*,and that death occurred, on the date stated above, at *4:00* m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
(Patent Foramen Ovale)(Duration)....yrs....mos....*2* ds.CONTRIBUTORY
(Secondary)(Duration)....yrs....mos....*2* ds.(Signed) *Edward R. Smith* M. D.*Aug 4*, 191*5* (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS).

At place of death....yrs....mos....*2* ds. In the State....yrs....mos....*2* ds.Where was disease contracted, if not at place of death? *Mercy Hospital*Former or usual residence *Mercy Hospital*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

*Alvin Herring**Aug 4*, 191*5*

20-UNDERTAKER

ADDRESS

1107 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087227

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 087227
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1746 E. Lanyale St. 8 WARD)

FULL NAME

(Residence in Baltimore: No. 1746 E. Lanyale St. 65 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widower

6-DATE OF BIRTH

April 9, 1838 (Month) (Day) (Year)

7-AGE

77 yrs. 3 mos. 25 ds. or less than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Germany

10-NAME OF FATHER

Carl Frank

11-BIRTHPLACE OF FATHER (State or country)

Germany

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Fred Mueller (Address) 1746 E. Lanyale

15.

AUG 4 - 1915

HARRY O. ANDREWS,

Barial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 3, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 27, 1915, to Aug 3, 1915.

that I saw him alive on Aug 2, 1915.

and that death occurred, on the date stated above, at 7:45 m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) 5 yrs. mos. ds.

Contributory (SECONDARY)

Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed)

Hubert A. Krumm, M. D. (Address) 1216 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery Aug 5, 1915

20-UNDERTAKER

ADDRESS

Henry Lutz 1007 N. Bond St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87228

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. *3188 Poppleton* ST. *21* WARD)

2-FULL NAME *Eliza J. Hoffman*

(Residence in Baltimore: No. *3188 Poppleton* St.; *—* yrs. *—* mos. *—* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-STATUS

Widow

Widow

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

Unknown

7-AGE

75

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House

Work

9-BIRTHPLACE

(State or country)

Md

10-NAME OF FATHER

George B. Botner

11-BIRTHPLACE OF FATHER

(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Wilhelm M. Visterhage

13-BIRTHPLACE OF MOTHER

(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Wilhelm J. Hoffman*

(Address) *318 Poppleton St*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 3

(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Jan, 191*5*, to, *Aug 3*, 191*5*,

that I saw her alive on *Aug 3*, 191*5*,

and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH* was as follows:

Bright Disease

(Duration) yrs. *6* mos. *—* ds.

Contributory (SECONDARY) *General Debility*

(Signed) *Jose E. Mink* M. D.

Aug 4, 191*5*. [Address] *1520 Hollins*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Dund Ridge

20-UNDERTAKER *John Herman X Son*

DATE OF BURIAL

Aug 5, 191*5*

ADDRESS *701 Hollins*

AUG 4 - 1915.

Filed....., 191

HARRY O. ANDREWS,

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87229

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C. 28

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 Etting St.)

St. 14 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Addie Smith

(Residence in Baltimore: No. 1719 Etting St.)

St. 3 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE Colored

5-SINGLE MARRIED Married

6-DATE OF BIRTH

(Month) Oct

(Day) 3

(Year) 1883

7-AGE

31

Yrs.

10

Mos.

ds.

If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE (State or country)

St. Marys City Md.

10-NAME OF FATHER

Maurice Edwards

11-BIRTHPLACE OF FATHER (State or country)

St. Marys City Md.

12-MAIDEN NAME OF MOTHER

Fernie Edwards

13-BIRTHPLACE OF MOTHER (State or country)

St. Marys City Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bernard Smith

(Address)

1719 Etting St. City

15-

AUG 4 - 1915

HARRY O. ANDREWS,

MARITAL PERMIT CLERK

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 3, 1915

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1915, to Aug 2, 1915, that I saw her alive on Aug 2, 1915, and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pul.

Contributory (SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87230		HEALTH DEPARTMENT-CITY OF BALTIMORE		92 (87230)	
PLACE OF DEATH		CERTIFICATE OF DEATH		REGISTERED No. C	
CITY OF BALTIMORE (No. 2110 Mt Royal Terr 3		ST. 67 WARD		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
2-FULL NAME Mrs Elizabeth Horner					
(Residence in Baltimore: No. 2110 Mt Royal Terr		St. 67 yrs. 3 mos. 28 ds.)			
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH	
3-SEX Female	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED, DIVORCED widow	16-DATE OF DEATH Aug 2, 1915		
6-DATE OF BIRTH April 7, 1848			(Month) (Day) (Year)		
7-AGE 64 yrs. 3 mos. 28 ds.			17. I HEREBY CERTIFY, That I attended deceased from Aug 19, 1915, to Aug 2, 1915, that I saw her alive on Aug 2, 1915, and that death occurred, on the date stated above, at 12.50 p.m. The CAUSE OF DEATH* was as follows: Lobes pneumonia		
8-OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer)			18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence		
9-BIRTHPLACE (State or country) Baltimore Md.			Contributory (SECONDARY) Heat prostration		
10-NAME OF FATHER James M. Ledum			(Duration) yrs. mos. ds.		
11-BIRTHPLACE OF FATHER Talbot Co Md			(Signed) James M. Calman M. D.		
12-MAIDEN NAME OF MOTHER Rachael G. Austin			Aug 3, 1915 (Address) 1822 Madison Ave		
13-BIRTHPLACE OF MOTHER Talbot Co. Md.			*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) Harry C. Thomas					
(Address) 2110 Mt. Royal Terr.					
15. AUG 4 - 1915 HARRY O. ANDREWS, Registrar					
16-PLACE OF BURIAL OR REMOVAL London Park Cemetery			DATE OF BURIAL Aug 5, 1915		
17-UNDERTAKER George J. Smith			ADDRESS 1800 W. Fayette St.		

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87231

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87231

CERTIFICATE OF DEATH

104

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *Shirley Ave E Ludwig Lane* ST. *15* WARD)

2-FULL NAME *Edwards B. Henry*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *Shirley Ave E Ludwig Lane* St. yrs. *9* mos. *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) *Single*

male white

6-DATE OF BIRTH

Oct. 7th, 1914
(Month) (Day) (Year)

7-AGE

9 yrs. *27* mos. *27* ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
none

9-BIRTHPLACE (State or country)

Balto.

10-NAME OF FATHER

Edw. B. Henry

11-BIRTHPLACE OF FATHER (State or country)

Ma.

12-MAIDEN NAME OF MOTHER

Isabelle Kenly

13-BIRTHPLACE OF MOTHER (State or country)

Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edw. B. Henry

(Address)

Shirley Ave E Ludwig Lane

AUG 4 - 1915

HARRY O. ANDREWS,

Marial Permit Clerk

Filed....., 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 2*, 1915, to *Aug 4*, 1915,

that I saw him alive on *Aug 4*, 1915,

and that death occurred, on the date stated above, at *4:30* m.

The CAUSE OF DEATH* was as follows:

Convulsions caused by "Intestinal Toxin"

Contributory (SECONDARY)

Exhaustion

(Signed)

J. M. L. L. L.

Aug 4, 1915

(Address)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Green Mount

DATE OF BURIAL

Aug. 5th, 1915

20-UNDERTAKER

E. M. Mitchell & Co. 1201 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Mercy Hospital* CITY OF BALTIMORE (No. *4* ST.: *4* WARD) REGISTERED NO. C
2-FULL NAME *Harold Stinnett* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *Mutual, Calvert Co, Md* S. *24* mo. *4* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *S.* (Write the word.)
6-DATE OF BIRTH, *November, 1903* (Month) (Day) (Year)
7-AGE, *12* yrs. *7* mos. *7* ds. If LESS than 1 day, *hrs.* or *min.*?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. *schoolboy* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Md*

PARENTS. 10-NAME OF FATHER, *unknown* 11-BIRTHPLACE OF FATHER (State or Country), *unknown* 12-MAIDEN NAME OF MOTHER, *unknown* 13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) *Hospital report* (Address) *Hospital report*

15-AUG 4 - 1915 HARRY O. ANDREWS Registrar. Filed *191* Serial Permit Glen

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 4th, 1915* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) And that said deceased came to his death on the day stated above.

THE CAUSE OF DEATH was as follows: *Tetanus, following an incised wound of the left foot, the result of an accident (hit with an ax. in his own hands.)* (Duration) *2* yrs. *2* mos. *2* ds.

CONTRIBUTORY (Secondary) *W. J. Savary, M. D.* (Signed) (Duration) *2* yrs. *2* mos. *2* ds. (Coroner.)

Aug 4, 1915 (Address) *1729 W. Madison Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs. *2* mos. *2* ds. In the *12* yrs. *2* mos. *2* ds.

Where was disease contracted, if not at place of death? *at Calvert Co, Md*

Former or usual residence *Calvert Co, Md*

19-PLACE OF BURIAL OR REMOVAL, *Governors Run, Calvert Co, Md* DATE OF BURIAL, *Aug 5, 1915*

20-UNDERTAKER, *Henry W. Means & Son* ADDRESS, *105 W. Calvert*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087233

HEALTH DEPARTMENT--CITY OF BALTIMORE

087233

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Orleans St. 6 WARD)

2-FULL NAME Sarah J. Vodery

(Residence in Baltimore: No. 1725 Orleans St.; — yrs. 3 mos. 1 ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and list out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX female 4-COLOR OR RACE colored 5-SINGLE MARRIED widow WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH March 4, 1830
(Month) (Day) (Year)

7-AGE 85 yrs. 4 mos. 29 ds. or min. ? If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work store keeper (b) General nature of industry, business, or establishment in which employed (or employer) chained work retail

9-BIRTHPLACE (State or country) Cambridge Md

10-NAME OF FATHER A. H. Peterson

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Rachel

13-BIRTHPLACE OF MOTHER (State or country) md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry A. Vodery
(Address) 1725 Orleans St.

15- AUG 4 - 1915 HARRY O. ANDREWS, Serial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 20 - 1915, to, Aug 2 - 1915, that I saw her alive on Aug 2 - 1915, and that death occurred, on the date stated above, at 7 A m. The CAUSE OF DEATH* was as follows:

Endocarditis

Contributory (SECONDARY) General Dropsy
(Duration) 3 yrs. — mos. — ds.

(Signed) W. H. Harris M. D.
Aug 4 - 1915 [Address] 1416 Pepper

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. — mos. — ds. In the State, yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

John W. Henderson

DATE OF BURIAL Aug 5, 1915

20-UNDERTAKER

314 Caroline st

ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87234

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87234

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *617 S. Patterson Park Ave* ST. *1* WARD)

2-FULL NAME

Agatha Kobylakiewicz

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *617 S. Patterson Park Ave* St. *1* yrs. *0* mos. *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6-DATE OF BIRTH *Dec 19, 1913*
(Month) (Day) (Year)

7-AGE *1* yrs. *7* mos. *16* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

Baltimore, Md.

10-NAME OF FATHER

Peter Kobylakiewicz

11-BIRTHPLACE OF FATHER
(State or country)

Austria

12-MAIDEN NAME OF MOTHER

Ekaterina Prunt

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ekaterina Kobylakiewicz

(Address)

617 S. Patterson Ave.

AUG 4 - 1915

HARRY O. ANDREWS,

Sanitary Permit Clerk

Filed *191*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 4, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY. That I attended deceased from

Aug 3, 1915, to, *Aug 4, 1915*.

that I saw her alive on *Aug 3, 1915*.

and that death occurred, on the date stated above, at *4 a* m.

The CAUSE OF DEATH* was as follows:

Francis Prumana

(Duration) yrs. mos. *1* ds

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Dr. J. J. ... M. D.
Aug 4, 1915 (Address) *2935 Eastern Ave*

*State the DISEASE CAUSING DEATH. or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Stanislaus

Aug 5, 1915

20-UNDERTAKER

ADDRESS

M. J. Sadowski

705 S. Ann St.

D. H. Mohr M. D.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 558 W. Biddle street,

St. 17 WARD)

2-FULL NAME

Rosa Bordley,

(Residence in Baltimore: No. 558 W. Biddle street,

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female,

4-COLOR OR RACE,

Colored,

5-SINGLE,

MARRIED, Married,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown,

(Month)

(Day)

(Year)

7-AGE,

45

yr.

2 mos.

2 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife,

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Maryland,

10-NAME OF FATHER,

Unknown,

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown,

12-MAIDEN NAME OF MOTHER

Unknown,

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard J. Bordley, husband

(Address) 558 W. Biddle street

15-

AUG 3 1915

Chas M. Sinclair
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August

31

1915.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry and that said deceased came to death
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation,

(Duration) yrs. mos. ds.

CONTRIBUTORY Rheumatism,
(Secondary)

(Duration) indefinite, ds.

(Signed) Frederick H. M. D.
(Coroner)

Aug. 4, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral

Aug 5 1915

20-UNDERTAKER

ADDRESS

Sam'l T. Hensley 558 W. Biddle

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *107 London Ave.* ST. *W* WARD)

2-FULL NAME

(Residence in Baltimore: No. *107 London Ave.* St. *20* yrs. *7* mos. *22* da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH.

January 2, 1854
(Month) (Day) (Year)

7-AGE.

60 yrs. *7* mos. *22* da.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Butter Dealer*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Washington, D.C.

10-NAME OF FATHER,

Charles Kuhlman

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Lucetta Hagaman

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. S. S. Kuhlman*(Address) *107 London Ave.*

15-

Filed *AUG 5 1915* *Chas. M. Sinclair**Kuhlmann*

CITY OF BALTIMORE

C87236

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 4, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1, 1914* to *Aug 4, 1915*, that I saw him alive on *Aug 3, 1915*, and that death occurred, on the date stated above, at *1:30 A.M.*

The CAUSE OF DEATH* was as follows:

Obdurate of Lung.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs. *3* mos. *3* da.
Obdurate of Lung
(Signed) *Howard W. Jones* M. D.
Aug 4, 1915. (Address) *107 London Ave.*

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St Paul's Lutheran Cemetery

DATE OF BURIAL,

Aug 7, 1915

20-UNDERTAKER

Mrs. A. Rohde

ADDRESS

730 Pa Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

C87237

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 1114 Woodyear St

REGISTERED NO. C

ST 16 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel Mathews

(Residence in Baltimore: No. 1114 Woodyear St

St.: yrs. 4 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Colored 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single
6-DATE OF BIRTH March 7, 1915
7-AGE 4 yrs. 28 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Balto Md

10-NAME OF FATHER

John W Mathews

11-BIRTHPLACE OF FATHER (State or country)

Balto Md

12-MAIDEN NAME OF MOTHER

Mary Smith

13-BIRTHPLACE OF MOTHER (State or country)

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter C Bacon
Garrett Hospital

15 AUG 5 - 1915
Filed 191

Blas M. Sinclair
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 4, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1915, to Aug 4, 1915, that I saw him alive on Aug 4, 1915, and that death occurred, on the date stated above, at 2:10 m. The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

Contributory (SECONDARY)

(Duration) yrs. mos. 4 ds

(Signed)

Walter C Bacon M. D.
8/4/15, 1915 (Address) Garrett Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St Peter

DATE OF BURIAL

Aug 6, 1915

20-UNDERTAKER

S. J. Johnson & Co.

ADDRESS

1400 Hopkins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

Aug 4, 1915

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 7)

WARD)

2-FULL NAME

(Residence in Baltimore: No. 7)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.

7 yrs. 7 mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

FILE

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 3.37 p.m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

REGISTRAR

C87240

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87240

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2604 Keyworth Ave* ST. *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Edward H. Lively Macom Lively*(Residence in Baltimore: No. *2604 Keyworth Ave*St. *54* yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

10th Jan., 1861
(Month) (Day) (Year)

7-AGE,

54 yrs. *6* mos. *19* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Leading Salesman

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Edward H. Lively

11-BIRTHPLACE OF FATHER

(State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Mary James

13-BIRTHPLACE OF MOTHER

(State or Country),

Richmond Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Mrs E. L. M. Lively

(Address).....

2604 Keyworth Ave

15-

Filed *AUG 5* 1915*Chas M. Sinclair*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 4, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *June 13th* 1915, to *Aug 4* 1915,that I saw him alive on *Aug 4* 1915,and that death occurred, on the date stated above, at *109* m.

The CAUSE OF DEATH* was as follows:

Myocardial Stenosis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia (Duration)..... yrs. mos. ds.

(Signed)..... M. D.

Aug 4, 1915 (Address)..... *Arlington Md*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Deals Island

DATE OF BURIAL,

Aug 6, 1915

20-UNDERTAKER

W. H. H. H. H. H.

ADDRESS

North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *616 S Fremont ST* 21 REGISTERED NO. C
 CITY OF BALTIMORE: (No. *616 S Fremont ST* ST.; *21* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and Block No. 18.)
 FULL NAME *Wm G Budeta*
 (Residence in Baltimore: No. *616 S Fremont* St.; *lifetime* yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)
 6-DATE OF BIRTH, *May 23rd*, 1878 (Month) (Day) (Year)
 7-AGE, *37* yrs. *3* mos. *11* ds. If LESS than 1 day, ...hrs. or...min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work *Laboren*
 (b) General nature of industry, business, or establishment in which employed (or employer) *General*

9-BIRTHPLACE, (State or Country), *Balto.*
 10-NAME OF FATHER, *Henry Budeta*
 11-BIRTHPLACE OF FATHER (State or Country), *Germany*
 12-MAIDEN NAME OF MOTHER *Sophia Grabbe*
 13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *George Budeta*
 (Address) *616 S Fremont*

15-*Geo M. Surchar*
 Filed *Aug 5 - 1915* 191. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *August 3rd*, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *June 18th* 1915, to *Aug 3rd* 1915, that I saw him alive on *Aug 3rd* 1915, and that death occurred, on the date stated above, at *8 A* m.
 The CAUSE OF DEATH* was as follows:

Bright's Disease
 (Duration) yrs. *8* mos. ds.
 CONTRIBUTORY *Chronic Endocarditis*
 (Secondary) (Duration) yrs. *5* mos. ds.
 (Signed) *Thomas J. O'Sullivan* M. D.
Aug 3rd 1915 (Address) *1075 W 2nd*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Western Cemetery *8/5*, 1915.

20-UNDERTAKER

W. J. Fickner & Son Address *Penn*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.; *4* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore No. *Catonsville* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Married
(Write the word.)

6-DATE OF BIRTH,

5 (Month) *5* (Day) *1891* (Year)

7-AGE,

6 yrs. *11* mos. *28* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Clerk**Custn Store*

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

PARENTS.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *May Iguale*(Address) *5 D. Dukeywood ne.*

15-

Filed

191

Chas. A. ...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 3, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 3 191*5*, to *Aug 3* 191*5*,that I saw him alive on *Aug 3* 191*5*,and that death occurred, on the date stated above, at *10:25 a.m.*

The CAUSE OF DEATH* was as follows:

*General Artery Sclerosis**Grav. of known*
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Grav. of known
(Duration) yrs. mos. ds.(Signed) *Edward P. ...* M. D.*Aug 3*, 191*5* (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *13 hrs* In the *State* yrs. mos. ds.Where was disease contracted, if not at place of death? *Custn Store*Former or usual residence *Catonsville Md.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*London Park**8/5*, 191*5*

20-UNDERTAKER

ADDRESS

W. J. ...

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 5 - 1915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1002 E. Balt* ST.; *5* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Zelda Cohen*(Residence in Baltimore: No. *1002 E. Balt St* St.; *25* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH *Aug*, *1849*

(Month)

(Day)

(Year)

7-AGE, *66*

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Russia*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Russia*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Lewis*(Address) *1419 E. Balt St*

15-

Filed *AUG 5 - 1915*

191

Charles M. McClay
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 5*, *1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 4*, *1915*, to *Aug 5*, *1915*, that I saw he alive on *Aug 5*, *1915*, and that death occurred, on the date stated above, at *1 a* m. The CAUSE OF DEATH* was as follows:*Respiratory Paralysis*

(Duration)....yrs....4....mos....da.

CONTRIBUTORY (Secondary) *Old age*

(Duration)....yrs....mos....da.

(Signed) *D. Wallenstein* M. D.*Aug 5*, *1915*. (Address) *6. S. Exeter St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs....mos....da. Stateyrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Hebron Mt. Cemetery Rd*DATE OF BURIAL *Aug 5*, *1915*20-UNDERTAKER *Jack Lewis*ADDRESS *1419 E. Balt St*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1012 N Carey*, ST.; *16* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Sarah Williams*(Residence in Baltimore: No. *1012 N Carey St* St.; *10* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Black

5-SINGLE,

Single

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

July unknown, 1915
(Month) (Day) (Year)

7-AGE,

37 yrs. *7* mos. da.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which

employed (or employer).

Home duties
House work

9-BIRTHPLACE,

(State or Country),

Washington DC

10-NAME OF FATHER,

*John Williams*11-BIRTHPLACE OF FATHER
(State or Country)*Washington*

12-MAIDEN NAME OF MOTHER

*Lucy Johnson*13-BIRTHPLACE OF MOTHER
(State or Country)*Alexandria Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Roberta H. Williams*(Address) *1012 N Carey St*

15-

*Aug 5, 1915**Charles M. Tucker*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 3, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Aug 1, 1915, to Aug 3, 1915,*that I saw him alive on *Aug 2, 1915,*and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH was as follows:

Enteritis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) *Exhaustion*

(Duration) yrs. mos. da.

(Signed) *Dr. Davis* M. D., 191... (Address) *923 N. Carrollton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Zion *Aug 5, 1915*

20-UNDERTAKER

ADDRESS

James H. Dennis *303 Keston*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1925 White* ST. *20* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1925 White* St. *3* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1N.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Colored**Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Not Known
(Month) (Day) (Year)

7-AGE,

18 yrs. mos. ds.If LESS than 1 day,
...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

House Worker

(b) General nature of industry, business, or establishment in which employed (or employer).

*At Home*9-BIRTHPLACE,
(State or Country),*Balt Md*

10-NAME OF FATHER,

*Harry Hearnshy*11-BIRTHPLACE OF FATHER
(State or Country),*Charles Co Md*

12-MAIDEN NAME OF MOTHER

*May Derry*13-BIRTHPLACE OF MOTHER
(State or Country),*S. Mary Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *May Derry*(Address) *1925 White St*

15-

AUG 5 - 1915

191

Chas M Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

8-2-15, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

7-3-15 191, to *8-2-15* 191,that I saw h *alive* on *11* 191,and that death occurred, on the date stated above, at *11 a*, m.

The CAUSE OF DEATH* was as follows:

*acute Peritonitis*CONTRIBUTORY
(Secondary)*Diarrhea, Acute*(Signed) *Ad. Carson* M. D.*8-2-15* 191... (Address) *1524 O Hill Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Auburn

DATE OF BURIAL,

August 5, 1915

20-UNDERTAKER

John H. Owens

ADDRESS

1222 Avenue M

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1603 Canton st ST. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1603 Canton st St.: yrs. 9 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,WIDOWED,OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

December 9, 1914
(Month) (Day) (Year)

7-AGE,

7 yrs. 25 mos. 25 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

none
Infant9-BIRTHPLACE,
(State or Country),10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wladyslaw Rydzewski(Address) 1603 Canton st

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH,

August 5, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
August 4 1915, to August 4 1915,
that I saw him alive on August 7 1915,
and that death occurred, on the date stated above, at 5 a.m.
The CAUSE OF DEATH* was as follows:Heart prostration

(Duration) yrs. mos. ds.

CONTRIBUTORY... Diphtheria
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wladyslaw Rydzewski M. D.August 5, 1915 (Address) 722 St. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.

DATE OF BURIAL,

Holy RosaryAug 6, 1915

UNDERTAKER

ADDRESS

William S. Patterson1618 Eastern AveFiled 9 27 1915 Charles M. Snelap Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *910 P. Wolfe St.*)

2-FULL NAME

Dominic Piotrowski

(Residence in Baltimore: No. *910 P. Wolfe St.*)

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

August 11, 1915
(Month) (Day) (Year)

7-AGE,

— yrs. — mos. — da.

If LESS than 1 day,
8 hrs. or — min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

Seaman

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Boleslaw Piotrowski

11-BIRTHPLACE OF FATHER

(State or Country)

Russia

12-MAIDEN NAME OF MOTHER

Kawra Longanowska

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Boleslaw Piotrowski*

(Address) *910 P. Wolfe St.*

15-

Filed

AUG 5 - 1915

Charles M. Snelau

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 11, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry* find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Atelectasis Pneumonia

(Duration) — yrs. — mos. — da.

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — da.

(Signed)

D. W. Jones
(Coroner)

M. D.

Aug 5, 1915 (Address) *3116 Eastern Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death — yrs. — mos. — da. State — yrs. — mos. — da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary

Aug 11, 1915

20-UNDERTAKER

ADDRESS

William Fialkowski 1611 Eastern Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *509 S. Bond.* ST.; *2* WARD)

REGISTERED NO. C

2-FULL NAME

Albin Budzynski

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *509 S. Bond. St.* St.; yrs., *6* mos., *20* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Jan.
(Month)*15*
(Day)*1915*
(Year)

7-AGE,

6 yrs., *20* mos., *20* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Albin Budzynski

11-BIRTHPLACE OF FATHER

(State or Country),

Balt.

12-MAIDEN NAME OF MOTHER

Katherine Kozak

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Albin Budzynski

(Address).

509 S. Bond.

15-

Filed *5* *1915*

19

Geo. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug
(Month)*4th*
(Day)*1915*
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 15th 1915, to *Aug. 4th* 1915,that I saw him alive on *"* 1915,and that death occurred, on the date stated above, at *7.30 P.* m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY *Gastro-Enteritis*
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Jacob B. Wimmer* M. D.*8-4*, 1915. (Address) *308 S. Bond.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Holy Rosary**Aug. 5, 1915*

20-UNDERTAKER,

ADDRESS

*Jacob Tractowski**428 S. Bond.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87249

CERTIFICATE OF DEATH

C87249

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

Sr.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH Aug 3, 1915 (Month) (Day) (Year)

7-AGE If LESS than 1 day, hrs. 2 mos. 2 ds. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balt. Md.

10-NAME OF FATHER Harold Hetrick

11-BIRTHPLACE OF FATHER (State or country) Balt. Md.

12-MAIDEN NAME OF MOTHER Elsie Conley

13-BIRTHPLACE OF MOTHER (State or country) Balt. Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mother

(Address) 703, N. 34th St.

15. AUG 5 - 1915. 191 Charles M. Leland

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug 5, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from Aug 3, 1915, to Aug 5, 1915, that I saw her alive on Aug 4, 1915, and that death occurred, on the date stated above, at 6 A. m. The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Signed) H. L. Fair M. D. Aug 5, 1915. (Address) 12 E 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Marys Hospital Aug 3, 1915

20-UNDERTAKER

ADDRESS

Chesrowith Long Chestnut Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087250

HEALTH DEPARTMENT—CITY OF BALTIMORE

087250

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 3811 Pleasant Place 13 WARD)

*FULL NAME

(Residence in Baltimore: No. 3811 Pleasant Place

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, April 23, 1915

7-AGE, 4 yrs., 11 mos., 11 da.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balt. Md.

10-NAME OF FATHER, Albert Davis

11-BIRTHPLACE OF FATHER (State or Country), Balt. Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Foster

13-BIRTHPLACE OF MOTHER (State or Country), Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Davis

(Address) 3811 Pleasant Place

15-

AUG 5 - 1915

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 4, 1915

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry C. Fennell M. D.

(Coroner) Aug 4, 1915 (Address) 1000 N. E. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Marys Hospital

DATE OF BURIAL, Aug 6, 1915

20-UNDERTAKER, Chenoweth & Son

ADDRESS, Chestnut Ave

C87251

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE

If LESS than 1 day,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE.
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)

and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gunshot wound of abdomen
(perforation of stomach and liver) the result
of Homicide

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

Aug 5, 1915 (Address) 1724 W. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Chesapeake Ave., Towson, Md.

Former or usual residence.....Towson, Md.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Felix B. Pye

107 E. Mulberry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *1708 Carlisle Place* ST. *8*)

*FULL NAME *Infant of Silas and Louise Fulty*

(Residence in Baltimore: No. *1708 Carlisle Place*)

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Female</i>	4-COLOR OR RACE, <i>Colored</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>Infant</i> (Write the word.)
6-DATE OF BIRTH, <i>Aug 4th, 1915</i> (Month) (Day) (Year)		
7-AGE, yrs. mos. ds. If LESS than 1 day, <i>2 hrs. or min.</i>		
8-OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <i>Infant</i>		
9-BIRTHPLACE, (State or Country), <i>Mo. d.</i>		
PARENTS.	10-NAME OF FATHER, <i>Silas Fulty</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Virginia</i>	
	12-MAIDEN NAME OF MOTHER, <i>Louise Warsaw</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Virginia</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Silas Fulty*

(Address) *1708 Carlisle Place*

15-AUG 5 - 1915
Filed 1915

HARRY O. ANDERSON
Bureau of Health
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 4th, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry*
(Inquest, autopsy or inquiry.)

And that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Atakosis Neonatorum

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Signed) *E. J. Russell* M. D.
(Coroner.)

Aug 5th, 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL,

Atthor Laurel cemetery Aug 5th, 1915

20-UNDERTAKER ADDRESS

1608 Mc Eldeny St Milton. Davis

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *226 N. Schroeder* ST.; *18* WARD)

2-FULL NAME

(Residence in Baltimore: No. *226 N. Schroeder* St.; *20* yrs., *11* mos., *12* ds)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*Negro*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) *Married*

6-DATE OF BIRTH,

August *22nd*, *1854*
(Month) (Day) (Year)

7-AGE,

60 yrs., *11* mos., *12* ds. If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

*AUG 5 - 1915*HARRY O. ANDREWS,
Serial Permit No. *101*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August *1st*, *1915*.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *August* *1st*, *1915*, to *August* *4th*, *1915*, that I saw him alive on *August* *3rd*, *1915*, and that death occurred, on the date stated above, at *2:50* a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis & Hypertrophy
(Duration) *1* yrs., *11* mos., *12* ds.CONTRIBUTORY
(Secondary)*Chronic Interstitial Nephritis*
(Duration) *8* yrs., *11* mos., *12* ds.(Signed) *Edward J. Glick*, M.D.*August* *4th*, *1915*. (Address) *20 N. Schroeder*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

*St. Luke's Church**Aug. 6., 1915.*

20-UNDERTAKER

ADDRESS

*Charles B. Jones**1118 N. Saratoga*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 S. Paca ST.; 21 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1002 S. Paca St.; — yrs., — mos., — da)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, Married, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Aug 7th, 1876 (Month) (Day) (Year)

7-AGE, 38 yrs., 11 mos., 26 da. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housewife (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Talbot Co. Md.

10-NAME OF FATHER, Geo. Thorpe

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Rebecca Hawkins

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Thorpe

(Address) 1002 S. Paca

15- AUG 5 - 1915 HARRY O. ANDREWS, REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 3, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1915, to Aug 3 1915, that I saw her alive on Aug 1 1915, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows: White Mucous Tuberculosis (Duration) — yrs., — mos., — da.

CONTRIBUTORY (Secondary) (Duration) — yrs., — mos., — da. (Signed) R. C. Raymond M. D. Aug 3, 1915 (Address) Not known

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Pine DATE OF BURIAL, Aug 6, 1915

20-UNDERTAKER, Geo. Raymond ADDRESS 1000 S. Paca

C87255

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2607 E. Fairmount Ave ST.; 6 WARD)

REGISTERED NO. C

2-FULL NAME

Frank E. Dorneling

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2607 E. Fairmount Ave St.; 2 yrs., 2 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH

May 23, 1915
(Month) (Day) (Year)

7-AGE

2 yrs., 13 mos., 13 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
Name

9-BIRTHPLACE, (State or Country),

Md (city)

10-NAME OF FATHER,

John F. Dorneling

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Henrietta Behrens

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Dorneling
(Address) 2607 E. Fairmount Ave

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 4, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 24 1915, to Aug 4 1915, that I saw him alive on Aug 4 1915, and that death occurred, on the date stated above, at 50 m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) P. P. Decker M. D.Aug 4 1915 (Address) 2607 E. Fairmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.....mos.....ds. In theyrs.....mos.....ds. State

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

Aug 6, 1915

20-UNDERTAKER

Christian Miller

ADDRESS

2337 Jefferson

15-

AUG 5 - 1915HARRY O. ANDREWSSerial Permit Clerk

Registrar.

N. B.—Every item of information should be carefully supplied. A.C.E. should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2607 E. Fairmount Ave ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard P. Doernling(Residence in Baltimore: No. 2607 E. Fairmount Ave St.; 2 yrs., 1 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

Single

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

May 23, 1915
(Month) (Day) (Year)

7-AGE,

2 yrs., 14 mos., 14 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) None9-BIRTHPLACE,
(State or Country),Md (City)

10-NAME OF FATHER

John F. Doernling11-BIRTHPLACE OF FATHER
(State or Country),Md

12-MAIDEN NAME OF MOTHER

Henrietta Rehm13-BIRTHPLACE OF MOTHER
(State or Country),Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John F. Doernling
(Address) 2607 E. Fairmount Ave

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 5, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 28 1915, to Aug 4 1915,that I saw him alive on Aug 4 1915,and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Gastroenteritis

.....

.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) C. W. Healy M. D.Aug 5, 1915 (Address) 2607 E. Fairmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore CemeteryAug 6, 1915

20-UNDERTAKER

ADDRESS

Christian Miller 2834 E. Pratt St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15-
AUG 5 - 1915

Filed..... 191.....

HARRY O. ANDREWS,

Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1608 E. Preston* ST. *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Lanisa Muinch*(Residence in Baltimore: No. *1608 E. Preston* St. *68* yrs., *6* mos., *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

Jan 9, 1847
(Month) (Day) (Year)

7-AGE,

68 6 24
yrs. mos. ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*none*

9-BIRTHPLACE, (State or Country),

Balt Md

10-NAME OF FATHER,

Adam Loudenlager

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

(State or Country),

Don't Know

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Caroline Bacon*(Address) *1608 E. Preston St*

15-

Filed *AUG 6 - 1915**1915*Registrar. *[Signature]*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 3, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *7/4* 1915, to *8/8* 1915, that I saw her alive on *8/3* 1915, and that death occurred, on the date stated above, at *5:45 P.* m.

The CAUSE OF DEATH* was as follows:

*Thrombocytosis +
apoplexy*
(Duration) *1* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

Syncope
(Duration) *1* yrs. *1* mos. *1* ds.
(Signed) *[Signature]* M. D.
8/4, 1915 (Address) *307-22 N. E.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore City Aug. 6, 1915

20-UNDERTAKER

ADDRESS

Miriam Cook 302 E. North Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *18* ST.; *18* WARD)

2-FULL NAME

(Residence in Baltimore: No. *828 W. Saratoga St.* St.; *75* yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

Widower
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Jan 28, 1840
(Month) (Day) (Year)

7-AGE.

75 yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Merchant

9-BIRTHPLACE.

(State or Country).

Md.

10-NAME OF FATHER.

*Andrew Koons*11-BIRTHPLACE OF FATHER
(State or Country).*Pennsylvania*

12-MAIDEN NAME OF MOTHER

*Mary Shealy*13-BIRTHPLACE OF MOTHER
(State or Country).*Pennsylvania*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alice Koons*(Address) *828 W. Saratoga*

15-

AUG 6 - 1915

Filed.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 4, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Aug 2, 1915, to Aug 4, 1915,*that I saw him alive on *Aug 4, 1915,*and that death occurred, on the date stated above, at *7:15 a.m.*

The CAUSE OF DEATH* was as follows:

*General Arterio-Sclerosis**Long term*
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)*Malnutrition*
(Duration) yrs. mos. ds.(Signed) *Edward J. Smith* M. D.*Aug 4, 1915* (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State *Life* yrs. mos. ds.Where was disease contracted, if not at place of death? *828 W. Saratoga St.*Former or usual residence *828 W. Saratoga St.*

19-PLACE OF BURIAL OR REMOVAL.

St. Oliver

DATE OF BURIAL.

Aug. 6, 1915.

20-UNDERTAKER

William Cook

ADDRESS

502 E. North

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1419 Poplar Grove St.* ST.; *16* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1419 Poplar Grove St.* St.; *4* yrs., *4* mos. *27* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

*Caucasian*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH,

Feb 8th 1915
(Month) (Day) (Year)

7-AGE,

4 yrs., *4* mos., *27* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

at home

9-BIRTHPLACE, (State or Country),

Baltimore Md.

PARENTS.

10-NAME OF FATHER,

Wm Joseph Culbertson

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Marguerite K. Lohr

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William J. Culbertson
(Address) *1419 Poplar Grove St.*

15-AUG 6 - 1915

Filed

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 5th 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *May 30th 1915*, to *August 5th 1915*, that I saw him alive on *August 5th 1915*, and that death occurred, on the date stated above, at *11:00 a.m.*

The CAUSE OF DEATH* was as follows:

Chronic Dysenteria(Duration) *2* yrs., *4* mos., *4* ds.

CONTRIBUTORY (Secondary)

Acute Catarrh of Bowels(Duration) *2* yrs., *4* mos., *4* ds.(Signed) *W. C. Grant* M. D.191... (Address) *1207 Poplar Grove St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *4* yrs., *4* mos., *4* ds. In the State *4* yrs., *4* mos., *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

New Cathedral

DATE OF BURIAL,

Aug. 10, 1915

20-UNDERTAKER

William Cook

ADDRESS

102 E. North

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1811 Covington* ST. *24* WARD)2-FULL NAME *Geo H. Stodtman Jr*(Residence in Baltimore: No. *1811 Covington* St. *24* yrs. *0* mos. *0* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH,

Aug 4, 1915
(Month) (Day) (Year)

7-AGE,

1 yrs. *0* mos. *0* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country), *Balto*10-NAME OF FATHER, *Geo H. Stodtman*11-BIRTHPLACE OF FATHER (State or Country), *Balto*12-MAIDEN NAME OF MOTHER *Paul Schlenkman*13-BIRTHPLACE OF MOTHER (State or Country), *W. Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo H. Stodtman*(Address) *1811 Covington*

15-

Filed *1915*

191

Chas M. Ludlow
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 5, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 4* 1915, to *Aug 5* 1915, that I saw him alive on *Aug 5* 1915, and that death occurred, on the date stated above, at *8:30 p.m.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) *1* yrs. *0* mos. *0* ds.CONTRIBUTORY (Secondary) *Congenital Deafness*(Duration) *1* yrs. *0* mos. *0* ds.(Signed) *Frank C. Jaeger* M. D.
8/6, 1915 (Address) *1234 Balto*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs. *0* mos. *0* ds. In the State *1* yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Balto Cemetery*DATE OF BURIAL, *Aug 6, 1915*20-UNDERTAKER *John J. Fields*ADDRESS *1200 St. Lombard St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

205 E. 23rd Street

CITY OF BALTIMORE: (No.

ST. 12 WARD)

2-FULL NAME

Ralph Leroy Akshurst

(Residence in Baltimore: No.

205 E. 23rd Street

St.; yrs. mos. ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and RR out No. 12.)

life

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

single

6-DATE OF BIRTH

July 29

1915

(Month)

(Day)

(Year)

7-AGE

7

If LESS than

1 day, hrs.

Yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Baltimore, City

10-NAME OF FATHER

Ernest Akshurst

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore, County

12-MAIDEN NAME OF MOTHER

Nellie B. Bosley

13-BIRTHPLACE OF MOTHER
(State or country)

Baltimore County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Ralph L. Akshurst

(Address) 205 E. 23rd Street

15-

Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 5, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 29, 1915, to, Aug 5, 1915,

that I saw him alive on Aug 5, 1915,

and that death occurred, on the date stated above, at 7:20 p.m.

The CAUSE OF DEATH* was as follows:

Premature birth
7 months Intra Uterine
(Duration) yrs. mos. 7 ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. 7 ds.

(Signed) Rosemary Akshurst M. D.

Aug 6, 1915 (Address) 2438 Hampden Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Jessups Church

DATE OF BURIAL

Aug 6, 1915

20-UNDERTAKER

A. S. Marshall

ADDRESS

3539 Falls Road

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87262 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH *Johns Hopkins Hosp* 8 REGISTERED NO. C
CITY OF BALTIMORE: (No. *8* ST. *8* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)
2-FULL NAME *Edward Stanley*
(Residence in Baltimore: No. *1819 Duncan St* St. *15* yrs. *15* mos. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
6-DATE OF BIRTH *Nov 15 1886*
(Month) (Day) (Year)
7-AGE *29* If LESS than
1 day, *hrs.*
yrs. mos. ds. or min?
8-OCCUPATION *Laborer*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE *Va.*
(State or country)
PARENTS
10-NAME OF FATHER *David Stanley*
11-BIRTHPLACE OF FATHER *Va.*
(State or country)
12-MAIDEN NAME OF MOTHER *Lucy Sanders*
13-BIRTHPLACE OF MOTHER *Va.*
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

AUG 6 - 1915 *Chas M Sinclair*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *August 4 1915*
(Month) (Day) (Year)

11- I HEREBY CERTIFY That I attended deceased from *July 29 1915* to *Aug 4 1915*, that I saw him alive on *Aug 4 1915*, and that death occurred, on the date stated above, at *4:35* p.m.
The CAUSE OF DEATH* was as follows:

Pyelonephritis, Double
About 10

Contributory (SECONDARY)

Acute Catarrh of Cystitis
(Duration) yrs. mos. ds.
(Signed) *William H. H. M.D.*
Aug 4 1915 (Address) *Johns Hopkins Hosp*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

12-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death *7* yrs. *7* mos. *7* ds. State *7* yrs. *7* mos. *7* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1819 Duncan St.*

13-PLACE OF BURIAL OR REMOVAL

Catholick Cemetery

14-UNDERTAKER

Wm J. Tamm

DATE OF BURIAL

Aug 7 1915

ADDRESS

1819 Duncan St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *300 W. Linnvale St*)

ST. *11* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Rita Elizabeth Hopwood*

(Residence in Baltimore: No. *300 W Linnvale St*)

St. yrs. mos. *16* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

6-DATE OF BIRTH *July 21, 1915* (Month) (Day) (Year)

7-AGE yrs. mos. *16* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *Infant* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore*

PARENTS 10-NAME OF FATHER *Chas. Austin Hopwood* 11-BIRTHPLACE OF FATHER (State or country) *Harpers Ferry, W. Va* 12-MAIDEN NAME OF MOTHER *Mary Elizabeth Kraft* 13-BIRTHPLACE OF MOTHER (State or country) *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Geo. T. Kemp* *St James Apartments* (Address) *Charles & Center Sts*

15. *AUG 6 - 1915* *Chas M Sunday* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August 5, 1915* (Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from *July 21*, 1915, to *August 5*, 1915, that I saw her alive on *August 4*, 1915, and that death occurred, on the date stated above, at *7 9* a.m. The CAUSE OF DEATH* was as follows:

Internal Haemorrhage (Duration) *about 1 hour* yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) *Geo. T. Kemp* M. D. *Aug 5, 1915* (Address) *St James Apartments*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *London Park Cem* DATE OF BURIAL *Aug 6, 1915*

20-UNDERTAKER *W. J. Fickner* ADDRESS *North Perry*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *4* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Rebecca Williams*(Residence in Baltimore: No. *University Hospital* St.; yrs., mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Negro*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH, 1886

(Month)

(Day)

(Year)

7-AGE, *39*

..... yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... *House Work*(b) General nature of industry, business, or establishment in which employed (or employer)..... *Servant*

9-BIRTHPLACE,

(State or Country), *Maryland*

PARENTS.

10-NAME OF FATHER, *William Williams*

11-BIRTHPLACE OF FATHER

(State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Lavinia Riley*

13-BIRTHPLACE OF MOTHER

(State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *Albert Stevens*(Address)..... *425 W. Camden St.*

15-

AUG 6 - 1915

191.

Chas. M. Tucker
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 5, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *8-5-1915*, to *8-5-1915*, that I saw her alive on *8-5-1915*, and that death occurred, on the date stated above, at *8 P* m.

The CAUSE OF DEATH* was as follows:

Peritonitis(Duration)..... yrs. mos. *2* ds.CONTRIBUTORY..... *Appendicitis*
(Secondary)*Acute Appendicitis* (Duration)..... yrs. mos. *2* ds.(Signed)..... *A. Coleman**8/5*, 1915 (Address) *University Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *1* ds. In the *39* yrs. mos. ds.Where was disease contracted, *Elkridge, Md.* if not at place of death?Former or usual residence *Elkridge - Md.*

19-PLACE OF BURIAL OR REMOVAL,

Elkridge Md

DATE OF BURIAL,

Aug 7, 1915

20-UNDERTAKER

Wm. Fickner Bros

ADDRESS

Rd. 1, Md.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87265

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87265

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 614 N. Glover

FULL NAME

Dymie Cerny

(Residence in Baltimore: No. 614 N. Glover

ST: 7

WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, ~~Lat. White~~ *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Infant*

6-DATE OF BIRTH, Aug 5th, 1915
(Month) (Day) (Year)

7-AGE, yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Infant*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *md*

10-NAME OF FATHER, *Frank Cerny*
11-BIRTHPLACE OF FATHER (State or Country), *Austria*
12-MAIDEN NAME OF MOTHER, *Antonie Moxa*
13-BIRTHPLACE OF MOTHER (State or Country), *Austria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Frank Cerny*
(Address), *614 N. Glover*

15-
Filed *9161 - 2 9th* *Chas M Sinclair*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 5th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry*
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cataleptosis Nervorum

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Charles J. Russell* M. D.
(Coroner.)

Aug 5th 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

St. Mary's Cemetery
Frank Cerny

Aug 5 1915
St. Mary's

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1119 Battery Ave* ST.; *24* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1119 Battery Ave* St.; *61* yrs., *6* mos., *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE.

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

1854
(Month) (Day) (Year)

7-AGE,

61

If LESS than 1 day.

yrs. mos. ds. hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

domestic
Private Laundry

9-BIRTHPLACE, (State or Country).

Maryland

10-NAME OF FATHER,

Harrison D. Barrell

11-BIRTHPLACE OF FATHER, (State or Country).

Maryland

12-MAIDEN NAME OF MOTHER,

Roseanna Corkran

13-BIRTHPLACE OF MOTHER, (State or Country).

Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. P. Jordan
1119 Battery Ave

15-

AUG 6 1915
Chas. M. Jordan
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 4, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *July* 191*4*, to *Aug 4* 191*5*, that I saw her alive on *Aug 4* 191*5*, and that death occurred, on the date stated above, at *10: P* m.

The CAUSE OF DEATH* was as follows:

Exhaustion

CONTRIBUTORY (Secondary)

Chronic Nephritis
(Duration) *3* yrs. *6* mos. *12* ds.(Signed) *J. P. Jordan* M. D.*Aug 6, 1915* (Address) *301 E. Cross St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Landon Park *Aug 7, 1915*

20-UNDERTAKER

ADDRESS

J. P. Jordan *301 E. Cross St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87267

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1829 N. Mount St.,

ST. 15 WARD)

2-FULL NAME Matilda Jones.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1829 N. Mount St.,

Str.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

6-DATE OF BIRTH Feb 26th, 1832 (Month) (Day) (Year)

7-AGE 83 yrs. 5 mos. 29 ds. 11 LESS than 1 day, hrs. or min.?

8-OCCUPATION None (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Charles Co Md.

10-NAME OF FATHER Geo. Brown

11-BIRTHPLACE OF FATHER Md.

12-MAIDEN NAME OF MOTHER Ann Mary Dyson

13-BIRTHPLACE OF MOTHER Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Alice Jones. (Address) 1829 N. Mount St.

15. Filed AUG 6 - 1915, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH August 5th, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 4th, 1915, to Aug. 5, 1915, that I saw her alive on Aug. 5th, 1915 and that death occurred, on the date stated above, at 7 P.M. The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 2 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) A. J. Davis M. D. 8-5, 1915 (Address) 800 W. 3rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Lorraine Cemetery DATE OF BURIAL Aug 7th, 1915

20-UNDERTAKER William J. E. 1234 Fayette Ave ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 C87268

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2719 Rayner Ave ST.; 16 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No.

2719 Rayner Ave

St.; 58 yrs., 7 mos. 08 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH,

Dec

(Month)

5

(Day)

1898
(Year)

7-AGE,

58

7

mos.

28

ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Foreman
in shoe factory

9-BIRTHPLACE,

(State or Country),

Baltimore

Md

10-NAME OF FATHER,

John P Engelhardt

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

George Engelhardt

(Address)

2719 Rayner Ave

15-

Filed

AUG 6 - 1915

Chas M. Lucier

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug

(Month)

6

(Day)

1915
(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 3 1915, to Aug 5 1915,

that I saw him alive on Aug 5 1915,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Aug 6, 1915 (Address) Franklin Sp. Hs.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Balto Cemetery

Aug 7, 1915

20-UNDERTAKER

ADDRESS

Chenoweth Son

Chestnut St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *902 S. Wolfe* ST.: *2* WARD)

2-FULL NAME

(Residence in Baltimore: No. *902 S. Wolfe* St.: yrs., *5* mos. *29* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *—*

6-DATE OF BIRTH, *Feb. 7, 1915*
(Month) (Day) (Year)

7-AGE, *5* yrs., *29* mos., *29* ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *Michael Muszkowski*

11-BIRTHPLACE OF FATHER (State or Country), *Austria*

12-MAIDEN NAME OF MOTHER, *Lenora Pisko*

13-BIRTHPLACE OF MOTHER (State or Country), *Russia Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Michael Muszkowski*

(Address) *902 S. Wolfe St.*

15- *Blumclair*

Aug 6 - 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 8, 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Aug 2* 191*5*, to *Aug 5* 191*5*, that I saw h*is* alive on *Aug 5* 191*5*, and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH* was as follows:

Eutero Coelitis

(Duration) yrs. mos. ds. *7*

CONTRIBUTORY *Cordic Ex. Lateralis*
(Secondary)

(Duration) yrs. mos. ds. *2*

(Signed) *William J. Rydman, M.D.*
Aug 8, 1915 (Address) *200 S. Calver St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Rosary*

DATE OF BURIAL, *Aug 7, 1915*

20-UNDERTAKER, *M. F. Sadowski*

ADDRESS, *405 S. Ann St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE FLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH
CITY OF BALTIMORE: (No. *816 S. Bond.* ST. *3* WARD) REGISTERED NO. C.
2-FULL NAME *Walenty. Mrs.*
(Residence in Baltimore: No. *816 S. Bond St.* St. *3* yrs. *5* mos. *26* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE MARRIED WIDOWED OR DIVORCED *Single*
(Write the word)
6-DATE OF BIRTH *Feb. 8, 1915*
(Month) (Day) (Year)
7-AGE *5 mos. 26 ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer) *Infant*

9-BIRTHPLACE
(State or country) *Baltimore*

PARENTS
10-NAME OF FATHER *Vincent. Mrs.*
11-BIRTHPLACE OF FATHER (State or country) *Russian Poland.*
12-MAIDEN NAME OF MOTHER *Annie. Balcer.*
13-BIRTHPLACE OF MOTHER (State or country) *Baltimore.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Annie Mrs.*
(Address) *816 S. Bond St.*

15-AUG 6 - 1915
Filed *191* *Chas M. Tucker* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *8* *25* *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 25, 1915*, to, *August 5, 1915*, that I saw him alive on *August 5th, 1915*, and that death occurred, on the date stated above, at *11 A m.*
The CAUSE OF DEATH* was as follows:

Yoster & niter & 7 lbs white

Contributory (SECONDARY) *Asphyxia*
(Duration) yrs. *1* mos. *10* ds.
(Signed) *W. A. Duckert* M. D.
8/5 1915 [Address] *422 S. Ann*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Holy Rosary* DATE OF BURIAL *Aug 6, 1915*
20-UNDERTAKER *William Fialkowski* ADDRESS *1618 Eastern Ave.*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *207 S. Chester* ST. *2* WARD)

2-FULL NAME *Regina Latoryska*

(Residence in Baltimore: No. *207 S. Chester St.* St. *2* yrs. *8* mos. *13* ds.)

REGISTERED NO. C. *104 087271*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*

4-COLOR OR RACE *White*

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) *Single*

6-DATE OF BIRTH *Nov. 23 1914*

(Month) (Day) (Year)

7-AGE *8 13*

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None
Infant

9-BIRTHPLACE
(State or country)

Baltimore

10-NAME OF FATHER

Stepan Lalenchuk

11-BIRTHPLACE OF FATHER
(State or country)

Russian Poland

12-MAIDEN NAME OF MOTHER

Sophia Lutryk Kowalski

13-BIRTHPLACE OF MOTHER
(State or country)

Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Stepan Lalenchuk*

(Address) *207 S. Chester*

15-

Filed *AUG 6 - 1915*

191

Charles M. Lueker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Aug 5th 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 3*, 191*5*, to *Aug 5*, 191*5*,

that I saw *her* alive on *Aug 3*, 191*5*,

and that death occurred, on the date stated above, at *6 46 p.*

The CAUSE OF DEATH* was as follows:

Gastric-Enteritis
2-3 weeks

Contributory
(SECONDARY)

Exhaustion

(Signed) *Chas. A. Neer*

(Duration) yrs. mos. ds.

(Address) *408 S. PATK Ave.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Holy Rosary*

DATE OF BURIAL *Aug 7 1915*

20-UNDERTAKER *William Galkowski*

ADDRESS *1618 Eastern Ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *106 Albemarle* ST.; *3* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *106 Albemarle* St.; *25* yrs., *—* mos., *—* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7-AGE,

80

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, business, or establishment in which

employed (or employer).

Reddler

9-BIRTHPLACE,

(State or Country),

Russia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

M. Goldfarb
1040 E. Lombard St.

15-

Filed.....

191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

August 6, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 15 1915, to *Aug 6 1915*,

that I saw her alive on *Aug 5 1915*,

and that death occurred, on the date stated above, at *4* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

uraemia

(Duration)..... yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. *5* mos. ds.

(Signed)..... *W. J. Baylin* M. D.

Aug. 6, 1915 (Address)..... *312 Airput*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *106 Albemarle St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Reburied Mt Carmel

Aug 6, 1915

20-UNDERTAKER

ADDRESS *1107 E*

S. Linnerson Bro Balt

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1039 Ridgely

2 FULL NAME Magdalene Eise

(Residence in Baltimore: No. 1039 Ridgely

REGISTERED NO. C

ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 2 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 MARRIED WIDOWED UNMARRIED (Write the word) undivided

6 DATE OF BIRTH Aug 12, 1822 (Month) (Day) (Year)

7 AGE 92 yrs. 11 mos. 23 ds. or less than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER John Lotz

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Nettie Myers

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Eise (Address) 1039 Ridgely st.

15 AUG 6 - 1915 191 Charles M. Sudas REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 5, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from Dec. 1914, to Aug 5, 1915.

that I saw him alive on Aug 5, 1915, and that death occurred, on the date stated above, at 10:50 a.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) James A. Huff M. D. Aug 5, 1915 (Address) Chesport Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Luthern Cemetery Aug 7, 1915

20 UNDERTAKER

ADDRESS

Isaac Syper 1600 W. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87274

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hosp. ST. 5

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Baby Hudrickson

(Residence in Baltimore: No.

429 N. Central Ave

St. yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR-DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

July

22

1915

(Month)

(Day)

(Year)

7-AGE,

11

ds.

10 LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Md

10-NAME OF FATHER,

Frank Hudrickson

11-BIRTHPLACE OF FATHER

(State or Country),

N. J.

12-MAIDEN NAME OF MOTHER

Henrietta Hardy

13-BIRTHPLACE OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Dr. R. L. Battisford

(Address)

J. H. Hosp.

15-

FED.

AUG. 6 - 1915

191

Charles M. Hudrickson

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug.

2

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I saw h alive on

191

and that death occurred, on the date stated above, at

m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. L. Mulla M. D.

Aug. 3, 1915 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

AUG 6 1915

20-UNDERTAKER

ADDRESS

FOR ANATOMICAL PURPOSES.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1929 East Lafayette Ave., 8 WARD)

(If death occurred in a hospital or institution, give its NAME, lastent of street and number and all out No. 18.)

2-FULL NAME

Emma E. Smith

St.: 10 yrs., mos. ds)

(Residence in Baltimore: No. 1929 East Lafayette Ave.

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

September 20, 1868, 1 (Month) (Day) (Year)

7-AGE,

46 yrs., 11 mos., 14 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

At Home

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Mathews Co., Va.

10-NAME OF FATHER,

Jefferson L. Brownley

11-BIRTHPLACE OF FATHER (State or Country),

Mathews Co., Va.

12-MAIDEN NAME OF MOTHER

Kate A. Forrest

13-BIRTHPLACE OF MOTHER (State or Country),

Mathews Co., Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Brownley

(Address) Norfolk, Va.

15-

Filed

9161-9-30-1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 4, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 3, 1915, to August 4, 1915, that I saw her alive on August 4, 1915, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. McDonald

Aug. 6, 1915. (Address) 1540 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn Cemetery

DATE OF BURIAL,

8/6/15, 1915

ADDRESS

20-UNDERTAKER

Garry W. Meas Eison 845 N. Calvert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Edward Mason(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs. mos. *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

July 11th, 1915
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day.

yrs. mos. *24* ds. hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

*AUG 7 - 1915**HARRY O. ANDREWS*Filed *1915* Serial *1* Permit *0101*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 5th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 11th, 1915*, to *Aug 5th, 1915*, that I saw him alive on *Aug 5th, 1915*, and that death occurred, on the date stated above, at *2:30 a. m.*

The CAUSE OF DEATH* was as follows:

Malnutrition and
Malassimilation(Duration) yrs. mos. *24* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. P. Boulton* M. D.No. 1 (Address) *615 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *24* ds. In the State yrs. mos. *24* ds.Where was disease contracted, if not at place of death? *St. Vincent's Infant Asylum*Former or usual residence *St. Vincent's Infant Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral *Aug 7, 1915*

20-UNDERTAKER

ADDRESS

M. Fahey & Sons *606 Lafayette St.*WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infirmary*)ST.: *14* WARD)

REGISTERED NO. C

2-FULL NAME

Victor Young

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Vincent's Infant Asylum*)St.; yrs. *2* mos. *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

May 7th, 1915
(Month) (Day) (Year)

7-AGE,

yrs. *2* mos. *28* ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1201 Division St.*

15-

AUG 7 - 1915

HARRY O. ANDREWS,

Baptist Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 5th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1st* 1915, to *Aug 5th* 1915, that I saw him alive on *August 5th* 1915, and that death occurred, on the date stated above, at *12:30 P. M.*

The CAUSE OF DEATH* was as follows:

M. abnutrition and mal-assimilation(Duration) yrs. *2* mos. *28* ds.CONTRIBUTORY
(Secondary)(Duration) yrs. *2* mos. *28* ds.(Signed) *J. P. Boulton* M. D.*Aug 6, 1915* (Address) *615 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. *18* ds. In the State yrs. *2* mos. *28* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *St. Vincent's Infant Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral**Aug 7, 1915*

20-UNDERTAKER

ADDRESS

*M. F. Baker - Sons 606 Lafayette*WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C.

CITY OF BALTIMORE: (No. *1334 N. Fulton St.* WARD *15*)

2-FULL NAME *Thomas J. Clarke*

(Residence in Baltimore: No. *1334 N. Fulton St.* St.; — yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Unknown

1852

7-AGE

63

If LESS than

1 day, hrs.,

1 day, mos. or min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Police

9-BIRTHPLACE

(State or country)

Ireland

10-NAME OF FATHER

Patrick Clarke

11-BIRTHPLACE OF FATHER

(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Mary Clarke

13-BIRTHPLACE OF MOTHER

(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bridget Clarke

(Address)

1334 N. Fulton St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August - 3rd 1915

17- I HEREBY CERTIFY, That I attended deceased from

July, 1915, to, *August 3rd* 1915,

that I saw him alive on *Aug 3rd* 1915,

and that death occurred, on the date stated above, at *11 P.* m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

Contributory (SECONDARY)

Hypertensive Pneumonia

(Signed)

G. M. Jones

Aug 5, 1915 [Address] *2802 Roslyn*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral *Aug 7* 1915

20-UNDERTAKER

ADDRESS

M. Fahy - 606 7th St.

18-AUG 7 - 1915

Filed

191

HARRY O. ANDREWS,

Marial Permit Clerk

REGISTRAR

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087279

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1900 W Lombard ST. 19 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1900 W Lombard St. 1 yrs. 3 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RR out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

May 3rd 1900

7-AGE

5 yrs. 3 mos. 3 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

Italy -

10-NAME OF FATHER

Salvatore Valenzia

11-BIRTHPLACE OF FATHER
(State or country)

Italy -

12-MAIDEN NAME OF MOTHER

Rosa Zito

13-BIRTHPLACE OF MOTHER
(State or country)

Italy -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Salvatore Valenzia

(Address)

1900 W Lombard St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 6th 1915

17- I HEREBY CERTIFY, That I attended deceased from July 20, 1915, to August 5, 1915, that I saw him alive on August 5, 1915, and that death occurred, on the date stated above, at 10 a.m. The CAUSE OF DEATH* was as follows:

Solar pneumonia

Contributory
(SECONDARY)

(Duration) yrs. mos. 28 ds.

(Signed)

S. Dmacek

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

New Cathedral

DATE OF BURIAL

Aug 7th 1915

20-UNDERTAKER

Patrick A. Hannon 1911 W Lombard

15- AUG 7 - 1915

HARRY O. ANDREWS,
Marial Permit Clerk.

REGISTRAR

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87280

CERTIFICATE OF DEATH

9291 C87280

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED

male

white

Single

6-DATE OF BIRTH

July 15, 1914

7-AGE

1 yrs. 11 mos. 11 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Baltimore Md.

10-NAME OF FATHER

Warren W. Dobbs

11-BIRTHPLACE OF FATHER (State or country)

Baltimore Ct.

12-MAIDEN NAME OF MOTHER

Sadie Merriken

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Warren W. Dobbs

(Address)

2012 E. Hoffman

15.

AUG 7 - 1915

HARRY O. ANDREWS,

Barlet Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 5, 1915

17. I HEREBY CERTIFY, That I attended deceased from

July 22, 1915, to Aug 5, 1915, that I saw him alive on Aug 5, 1915, and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Duration) yrs. 14 mos. 14 ds.

Contributory (SECONDARY) Cerebral complications

(Duration) yrs. 2 mos. 2 ds.

(Signed) H. Austin Selcher M. D.

Aug 6, 1915 (Address) 2250 E. Hoffman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

Aug. 7, 1915

20-UNDERTAKER

ADDRESS

Roll. J. Turner 1442 N. Brady

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2333 Madison Ave ST. 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Pauline Blumheim(Residence in Baltimore: No. 2333 Madison Ave St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Widowed

6-DATE OF BIRTH, June 9, 1857 (Month) (Day) (Year)

7-AGE, 58 yrs., 1 mos., 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 1

9-BIRTHPLACE, (State or Country), Balto Md

10-NAME OF FATHER, Herman Shauhouse

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Naamah Halbeim

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam'l Halbeim

(Address) 2333 Madison Ave

15-

AUG 7 - 1915 HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 6, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY. That I attended deceased from October 1914 to Aug 6 1915, that I saw h er alive on Aug 5 1915, and that death occurred, on the date stated above, at 9:59 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy and hemorrhages

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Nephritis & high blood pressure

Hebephlegia (Duration) 3 yrs. 5 mos. ds.

(Signed) Sam'l Halbeim M. D.

Aug 6, 1915 (Address) 1937 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Hebrew Friendship Soc, 1915

20-UNDERTAKER ADDRESS

Jahruco Co 1611 Madison Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87282		HEALTH DEPARTMENT—CITY OF BALTIMORE		170		C87282	
PLACE OF DEATH				CERTIFICATE OF DEATH			
CITY OF BALTIMORE (No. 1826 E. Oliver		ST. 8		WARD 8		REGISTERED NO. C	
2-FULL NAME William Parker				(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)			
(Residence in Baltimore: No. 1826 E. Oliver				St. 55 yrs. mos. ds.)			
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH			
3-SEX Male	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED OR DIVORCED Widower		16-DATE OF DEATH Aug 5, 1915			
6-DATE OF BIRTH June 25, 1835				(Month) (Day) (Year)			
7-AGE 80 yrs. 1 mos. 10 ds.				IF LESS than 1 day, hrs. or min.?			
8-OCCUPATION Distiller				17- I HEREBY CERTIFY, That I attended deceased from May 4, 1915, to Aug 5, 1915; that I saw him alive on Aug 4, 1915; and that death occurred, on the date stated above, at 12:20 p.m. The CAUSE OF DEATH* was as follows: Chronic Nephritis			
9-BIRTHPLACE Winchester Va				(Duration) yrs. 4 mos. ds.			
10-NAME OF FATHER Robert Parker				Contributory (SECONDARY)			
11-BIRTHPLACE OF FATHER Virginia				(Duration) yrs. mos. ds.			
12-MAIDEN NAME OF MOTHER Binninger				(Signed) John T. Avery M. D.			
13-BIRTHPLACE OF MOTHER Virginia				Address 1603 B. Street			
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
(Informant) Charles J. Brack				18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)			
(Address) 2434 E. Oliver St				At place of death yrs. mos. ds. State yrs. mos. ds.			
15-AUG 7 - 1915				Where was disease contracted, If not at place of death? Former or usual residence			
Filed 1915				19-PLACE OF BURIAL OR REMOVAL Greenmount			
HARRY O. ANDREWS, Registrar				DATE OF BURIAL Aug 8, 1915			
Burial Permit Clerk				20-UNDERTAKER Geo. W. Little			
				ADDRESS 531 N. Fremont Av			

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

X

C87284

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

Non-resident.

St.; yrs. mos. ds.)

CORONER'S CERTIFICATE OF DEATH.

5-SINGLE.
MARRIED, Single,
WIDOWED,
OR DIVORCED.
(Write the word.)

Unknown, /
 (Month) (Day) (Year)

It LESS than 1 day.
...hrs. or....min.

Day laborer,
Steel works,

North Carolina.

Unknown.

Unknown,

Unknown.

Unknown.

(Informant) Mary Johnson, friend,

(Address).....112..S...Caroline..street..

191. *Chris H. Tucker*

August.....5th....., 1915.
(Month) (Day) (Year)

7- I HEREBY CERTIFY, That I took charge of the
remains described above, held an inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-
inquiry...and that said deceased came to his death
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock and internal haemorrhage.....
due to an accidental crushing of...
the abdomen whilst at work on a...
travelling crane.....

yes..... no.....

CONTRIBUTORY
(Secondary)
..... (Duration) mo. da.
(Signed) *F. Frederick Hempel* M. D.
..... (Coroner.)
Aug. 6th 15 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... 2 hours ... In the State... Unknown...

Where was disease contracted, if not at place of death?.....
Sparrow's point, Md.....

Former or usual residence.....

10-PLACE OF BURIAL OR REMOVAL, <i>Asbury Cemetery</i>	DATE OF BURIAL AUG. 7 - 1915
--	--

20-UNDERTAKER	ADDRESS
ARMSTRONG-DENNY CO.	715 L. & L. St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.

Yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and full out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Female

White

Single

6-DATE OF BIRTH

Dec 27

(Month)

(Day)

1835

(Year)

7-AGE

79

Yrs.

7

mos.

9

ds.

If LESS than 1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Baltimore Md

10-NAME OF FATHER

Geo. W. Tucker

11-BIRTHPLACE OF FATHER (State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Rebecca Tucker

13-BIRTHPLACE OF MOTHER (State or country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James R. Tucker

(Address)

1527 Park Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 6th 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY. That I attended deceased from July 24th, 1915, to Aug 6th 1915, that I saw her alive on Aug 6th 1915, and that death occurred, on the date stated above, at 3:45 P. M. The CAUSE OF DEATH* was as follows:

Coma of Senile dementia

4 hours.

(Duration)

Yrs.

Mos.

Ds.

Contributory (SECONDARY)

Broncho-pneumonia

(Duration)

Yrs.

Mos.

Ds.

(Signed) J. B. E. Seegar

M. D.

Aug 6th 1915 (Address) 1529 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

Yrs.

Mos.

In the

ds. State

Yrs.

Mos.

Ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery

Aug 8, 1915

20-UNDERTAKER

ADDRESS

E. M. Mitchell & Co

1201 W. Fayette

AUG 7 - 1915

Filed

191

Charles M. Sinclair

REGISTRAR

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

Johns Hopkins Hosp ST. 7
Edward McMahon
3706 Chester Place Highgate Station
St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male
4-COLOR OR RACE White
5-SINGLE MARRIED WIDOWED OR DIVORCED Single
6-DATE OF BIRTH April 24 1915
7-AGE 3 yrs. 3 mos. ds. or min.?
8-OCCUPATION None
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

16-

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

August 5 1915
I HEREBY CERTIFY, That I attended deceased from August 5th, 1915, to August 5th, 1915, that I saw him alive on August 5, 1915, and that death occurred, on the date stated above, at 7:20 p.m.
The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

Contributory (SECONDARY)

(Signed)

August 6 1915 [Address] Johns Hopkins Hosp

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. 1 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 3706 Chester Place

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Trinity Cemetery

Aug 8 1915

20-UNDERTAKER

ADDRESS

Zirkler & Zirkler

1739 E. Egan St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1908 Etting street,

2-FULL NAME Alfreda West,

(Residence in Baltimore: No. 1908 Etting street,

ST. 14 WARD

28 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

lifetime St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female,

4-COLOR OR RACE,

Colored,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single, (Write the word.)

6-DATE OF BIRTH,

July 27th, 1896.

(Month) (Day) (Year)

7-AGE,

19 yrs. 0 mos. 2 ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Mack West,

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland,

12-MAIDEN NAME OF MOTHER

Georgianna Water,

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mack West, father,

(Address) 1908 Etting street.

15-

Filed.

Aug 7 - 1915

101

Charles M. Sinclair

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 5th, 1915.

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry and that said deceased came to her death (Inquest, au-

topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner.)

Aug. 6th 1915 (Address) 3310 W. North av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Mt. Zion Cemetery

Aug. 8, 1915

20-UNDERTAKER

ADDRESS

Deane H. Holland

517 Robert St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *12. E. Hill* ST.; *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Patricia Cosgrove*(Residence in Baltimore: No. *12. E. Hill* St.; *44* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*wid*

6-DATE OF BIRTH,

Aug 1, 18*59*
(Month) (Day) (Year)

7-AGE,

56 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Hotel Watchman*9-BIRTHPLACE,
(State or Country),*Ireland*

10-NAME OF FATHER,

*John Cosgrove*11-BIRTHPLACE OF FATHER
(State or Country),*Ireland*

12-MAIDEN NAME OF MOTHER

*Mary Gentry*13-BIRTHPLACE OF MOTHER
(State or Country),*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Cosgrove*(Address) *12. E. Hill St.*

15-

Filed

*AUG 7**1915**Chas M. Ireland*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 5, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 1* 191*5*, to *Aug 5* 191*5*, that I saw him alive on *Aug 5* 191*5*, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Paralysis existing for two years
(Duration) *2* yrs. mos. ds.CONTRIBUTORY *acute congestion of lungs*
(Secondary) (Duration) *5* yrs. mos. ds.(Signed) *E. F. McIlhenny, M. D.*
....., 191... (Address) *115 W. Franklin*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery Aug 9, 1915

20-UNDERTAKER

ADDRESS

*F. A. Krause 703 Hanover*WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87289

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2433 Foster Ave*)ST.: *1* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *2433 Foster Ave*)St.: *68* yrs., *—* mos., *—* ds.)

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Dark brown, 1
(Month) (Day) (Year)

7-AGE,

61 yrs., *—* mos., *—* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*At Home*9-BIRTHPLACE,
(State or Country).*Maryland*

10-NAME OF FATHER,

George Solomon

11-BIRTHPLACE OF FATHER

(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Margaret Leffler

13-BIRTHPLACE OF MOTHER

(State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles Hill*(Address) *2433 Foster Ave*

15-

Filed

AUG 7 - 1915

191

Cha. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 6, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *August 2* 1915, to *August 6* 1915, that I saw her alive on *August 6* 1915, and that death occurred, on the date stated above, at *5:45* pm.
The CAUSE OF DEATH* was as follows:*Cirrhosis of liver*

(Duration)

*Unknown*CONTRIBUTORY
(Secondary)

(Duration)

(Signed) *Dr. Janney*

August 6, 1915

(Address)

2431 Foster Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill

DATE OF BURIAL,

Aug 8, 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E North

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 938 Poplar Grove Ave. ST.; 16 WARD)

2-FULL NAME

(Residence in Baltimore: No. 938 Poplar Grove Ave

St.; 20 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widowed

6-DATE OF BIRTH,

March 17th, 1847

7-AGE,

68 yrs., 4 mos., 20 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work,

(b) General nature of industry, business, or establishment in which employed (or employer)

House Wives

9-BIRTHPLACE, (State or Country),

West Va.

10-NAME OF FATHER,

John Snoddeal

11-BIRTHPLACE OF FATHER (State or Country),

West Va

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

West Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lucy M. Baker

(Address)

938 Poplar Grove St

AUG 7 - 1915

Filed

191

Chas. M. Snoddeal

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 6th, 1915

17- I HEREBY CERTIFY, That I attended deceased from

Aug 4th 1915, to Aug 6 1915.that I saw her alive on Aug 5th 1915,

and that death occurred, on the date stated above, at 11:50 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration).....yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs. 2 mos. ds.

(Signed).....J. H. Snyder M. D.

Aug 6, 1915 (Address) 1425 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cem

DATE OF BURIAL,

Aug 8, 1915

20-UNDERTAKER

Mr. & Mrs. John H. Trefel 80 W. Fayette St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103
C87291
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1120 Ething* ST.; *17* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1120 Ething* St. *life time* yrs., mos. ds.)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Unknown, 18*44* (Month) (Day) (Year)

7-AGE,

74

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Postman*(b) General nature of industry, business, or establishment in which employed (or employer), *Left Store*9-BIRTHPLACE, (State or Country), *Baltimore, Maryland*10-NAME OF FATHER, *David Ashley*11-BIRTHPLACE OF FATHER (State or Country), *Md*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Sarah Ashley*(Address) *1120 Ething*

15-

Filed *Aug 7 - 1915*

191

Chas. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 4, 1915. (Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 7 - 1915*, to *Aug 4 - 1915*.that I saw him alive on *Aug 4*, 191*5*.and that death occurred, on the date stated above, at *11 P.* m.

The CAUSE OF DEATH was as follows:

Acute Gastritis(Duration) *1* yrs. *1* mos. *1* da.
CONTRIBUTORY (Secondary) *Senility, heart defect*(Signed) *F. N. Cardoso* M. D.8-5-1915. (Address) *1524 Grand Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Ambrose

DATE OF BURIAL,

Aug 5, 1915

20-UNDERTAKER,

Carroll T. Tandy

ADDRESS,

*548 N. Belle*WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *148 Coelin A* ST. *W* WARD)

2-FULL NAME

(Residence in Baltimore: No. *148 Coelin A* St.; yrs. *7* mos. *6* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

*Single**Married,**Widowed,**OR DIVORCED,**(Write the word.)*

6-DATE OF BIRTH,

Dec 31, 1914
(Month) (Day) (Year)

7-AGE,

7 yrs. *6* mos. *6* ds.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE,
(State or Country),*Baet*

10-NAME OF FATHER,

*James Shealy*11-BIRTHPLACE OF FATHER
(State or Country),*Baet*

12-MAIDEN NAME OF MOTHER

*Emily Rejwood*13-BIRTHPLACE OF MOTHER
(State or Country),*Baet*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Shealy*(Address) *148 Coelin A*

15-

Filed *1915*

191

Charles M. Lavelle

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 6, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 25* 191*5*, to *Aug 6* 191*5*, that I saw her alive on *Aug 5* 191*5*, and that death occurred, on the date stated above, at *9:30* m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis(Duration) *14* yrs. *14* mos. *14* ds.CONTRIBUTORY
(Secondary)(Duration) *14* yrs. *14* mos. *14* ds.(Signed) *Howard W. Young* M. D.*Aug 6* 191*5*. (Address) *Dorchester*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery Aug 8, 1915

20-UNDERTAKER

ADDRESS

*George A. Paul & Son, Ltd.*WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *9* *Wd. General Hospital* ST.; *9* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Erema Carter

(Residence in Baltimore: No. *2635 Boone St*

St.: *18* yrs., *18* mos., *18* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

August, *1897*
(Month) (Day) (Year)

7-AGE,

18 yrs., *7* mos., *7* da.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer). *at home*

9-BIRTHPLACE, (State or Country),

Baltimore Mo

10-NAME OF FATHER,

Henry Carter

11-BIRTHPLACE OF FATHER (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Mary Stungfeller

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Carter*

(Address) *2635 Boone St*

15-

AUG 7 - 1915 191... *Chas M. Sinclair*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

August, *6*, *1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 19* 1915, to *Aug 6* 1915, that I saw her alive on *Aug 6* 1915, and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation (Acute)
(contracted pelvis)
(Duration) *7* yrs., *7* mos., *7* da.

CONTRIBUTORY (Secondary)

Cervical Section (op.)
(Duration) *7* yrs., *7* mos., *7* da.

(Signed)

Frank E. Shipley M. D.
Aug. 6., 1915. (Address) *Wd. Genl. Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *19* yrs., *18* mos., *18* da. In the State *18* yrs., *18* mos., *18* da.

Where was disease contracted, if not at place of death? *7635 Boone St*

Former or usual residence *2635 Boone St*

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

8/9, 1915

20-UNDERTAKER,

Sam'l T. Hunsby

ADDRESS

578 M. Beale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087234

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

189

087234

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2367 McCulloh*.)

2-FULL NAME *Rebecca Laven*

(Residence in Baltimore: No. *None*.)

REGISTERED NO. C.

St. *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

{ Chicago } St.: yrs., mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow* (Write the word.)

6-DATE OF BIRTH, *Oct* *5*, *1868* (Month) (Day) (Year)

7-AGE, *46* yrs. *8* mos. *1* ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer), *At*

9-BIRTHPLACE, (State or Country), *Russia*

10-NAME OF FATHER, *Fruch*

11-BIRTHPLACE OF FATHER (State or Country), *Russia*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George Laven*

(Address) *2267/1 Edzie Boul. Chicago*

15- *JUL 7 - 1915*

Filed *101* *Cl. Duclair*

This certificate was accepted by Watchman July 7-1915 by Watchman after house.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug* *6th*, *1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.)

and that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Unknown Chronic Disease

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Saml. Winterberg* M. D.

Aug. 7th 1915 (Address) *2302 Madison St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. *10* ds. In the State ... yrs. ... mos. *10* ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence *Chicago, Ill.*

19-PLACE OF BURIAL OR REMOVAL, *Chicago, Ill.* DATE OF BURIAL, *Aug 7*

20-UNDERTAKER, *Saml. Winterberg* ADDRESS, *188 N. McRay*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1629 Linnian* ST.; *14* WARD)

REGISTERED NO. C

2-FULL NAME *Thomas Ball*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1629 Linnian* at St.; *18* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male.

4-COLOR OR RACE.

Codad

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

6-27

(Month)

(Day)

(Year)

7-AGE.

43

yrs.

mos.

da.

If LESS than 1 day.

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Labo.

(b) General nature of industry, business, or establishment in which employed (or employer).

General.

9-BIRTHPLACE, (State or Country).

Va

10-NAME OF FATHER.

Dont know

11-BIRTHPLACE OF FATHER (State or Country).

Va

12-MAIDEN NAME OF MOTHER

Dont know

13-BIRTHPLACE OF MOTHER (State or Country).

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Sadon*(Address) *515 N. Carlton*

15-AUG 8 - 1915

Filed..... 191

191

Charles M. Suttan

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 6, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 27 1915, to *August 1915*that I saw *him* alive on *August 5 1915*and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH* was as follows:

Typhoid

(Duration)

18 mos. ds.

CONTRIBUTORY (Secondary)

Typhoid

(Duration)

18 yrs. mos. ds.(Signed) *Dr. W. H. Keenan* M. D.*August 6 1915* (Address) *708 Cedar St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

White Star *Aug 8, 1915*

20-UNDERTAKER

ADDRESS *144 N. Mount St.**Wilbur Brown*

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

087296

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 542 Gold St

St. 14

WARD)

2 FULL NAME Frederick H. Farrell

(Residence in Baltimore: No. 542 Gold St

Str.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and full set No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M	4 COLOR OR RACE C	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single
6 DATE OF BIRTH April 10 th 1915 (Month) (Day) (Year)		
7 AGE yrs. 4 mos. ds.		If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Infant		

9 BIRTHPLACE
(State or country)

Balto md

PARENTS

10 NAME OF FATHER

Joseph A Farrell

11 BIRTHPLACE OF FATHER
(State or country)

md

12 MAIDEN NAME OF MOTHER

Blanche Sheppardson

13 BIRTHPLACE OF MOTHER
(State or country)

ala

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph A Farrell
542 Gold

(Address)

15

AUG 8 - 1915

191

Charles M. Sullivan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

8/7th 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from 8/1, 1915, to 8/7, 1915, that I saw him alive on 8/6, 1915, and that death occurred, on the date stated above, at 8 A.M. The CAUSE OF DEATH* was as follows:

An Gastro-enteritis

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds

(Signed)

8/7, 1915 (Address) 2129 Bond Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

St Peters Cemetery

DATE OF BURIAL

Aug 9th 1915

20 UNDERTAKER

Felix B Pye

ADDRESS

102 Connelly

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2102 Westwood Ave.* St. *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2102 Westwood Ave.* St. *55* yrs. *3* mos. *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F.

4-COLOR OR RACE.

*Wht*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Married*

6-DATE OF BIRTH,

Apr. 27th 1880
(Month) (Day) (Year)

7-AGE,

75 3 11
yrs. mos. ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION,

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Housewife*

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER

(State or Country),

Ger

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country),

Ger

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ms Augusta Arney

(Address)

2614 Bruce St.

15-

Filed

1915

Chas M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 7th 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *1914* to *Aug 7 1915*,
that I saw him alive on *Aug 6th 1915*,
and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH* was as follows:

*Fatal myocardial disease*CONTRIBUTORY (Secondary) *Dropsy of heart*
(Duration) yrs. *15* mos. *15* ds.(Signed) *Ed. Smith* M. D.*Aug 7, 1915* (Address) *1605 N. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn Cem

DATE OF BURIAL,

Aug 10, 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E North Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087293

HEALTH DEPARTMENT—CITY OF BALTIMORE

81

087293

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2420 Green Mount Ave ST.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Anderson(Residence in Baltimore: No. 2420 Green Mount Ave St.; 69 yrs., 11 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, Widower
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Aug 6, 1845
(Month) (Day) (Year)

7-AGE,

69 yrs., 11 mos., 29 ds.If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Merchant
Retired9-BIRTHPLACE,
(State or Country),Balto. Md

10-NAME OF FATHER,

William Anderson

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella S. Anderson(Address) 2420 Green Mount

15-

Filed AUG 8 - 1915

191

Charles M. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 6, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 2, 1915, to Aug 6, 1915, that I saw him alive on Aug 5th, 1915, and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:Arterio Sclerosis(Duration) 3 yrs. — mos. — ds.CONTRIBUTORY
(Secondary)(Duration) 1 yrs. — mos. — ds.Signed) M. A. Lee M. D.
Aug 7, 1915 (Address) 12 E. 25th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death 69 yrs. 11 mos. 29 ds. In the State 1 yrs. 11 mos. 29 ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore, Md Aug 8, 1915

20-UNDERTAKER

ADDRESS

William Cook 502 E NorthWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87299 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 10 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., 2 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed AUG 8 1915

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1915, to Aug 8 1915, that I saw him alive on Aug 7 1915, and that death occurred, on the date stated above, at 20, m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFAINTING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087300

HEALTH DEPARTMENT—CITY OF BALTIMORE

087300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *East Falls Ave, Fleet* ST.: *5* WARD)

2-FULL NAME *Edna Dorsey*

(Residence in Baltimore: No. *312 N. Central Ave*

169
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. *9* mos. *9* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*

4-COLOR OR RACE, *Colored*

5-SINGLE, MARRIED, *Single*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *May 3, 1906*

7-AGE, *9 yrs. 2 mos. 2 ds.*

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *at school*
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *Columbus Hill*

11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*

12-MAIDEN NAME OF MOTHER, *Sarah Dorsey*

13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sarah Hill*

(Address) *312 N. Central Ave*

15-

Filed *1915*

1915

Registrar. *Chas. H. Sinclair*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 9, 1915*

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *V. W. Jones* M. D.

Aug 7, 1915 (Address) *3116 Osbourne St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, *Laurel Cem.*

DATE OF BURIAL, *Aug 8, 1915*

20-UNDERTAKER

ADDRESS

Mrs. J. S. Locks

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87301

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87301

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2132 David Hill Ave. St. 14

2-FULL NAME

(Residence in Baltimore: No. 2132 David Hill Ave. St. 14

REGISTERED NO. C. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and Rm. or No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from July 20, 1915, to Aug 7, 1915,

that I saw her alive on Aug 7, 1915, and that death occurred, on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH* was as follows:

Cordis Failure, Cordis Enlargement

Contributory (SECONDARY) Subacute Bronchitis and Emphysema

(Signed) J. H. Wright

Aug 7, 1915 [Address] 1209 T Street

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 S. High St. ST. 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Hurwitz(Residence in Baltimore: No. 123 High St.)St.; 68 yrs., — mos., 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

M

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

March 14, 1827
(Month) (Day) (Year)

7-AGE,

88 yrs., — mos., — ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Retired

(b) General nature of industry, business, or establishment in which employed (or employer).

Clothing Mfg.

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

Mordecai Hurwitz

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Hurwitz(Address) 123 S. High St.

15-

Filed AUG 8 1915

191

Charles G. Lelair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 6, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 17, 1915, to August 6, 1915, that I saw him alive on August 6, 1915, and that death occurred, on the date stated above, at 9:45 AM.

The CAUSE OF DEATH* was as follows:

Respiratory paralysis(Duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)

Urinary Calculus

(Duration)

yrs. mos. 16 ds.(Signed) M. St. Aarmon

M. D.

191... (Address) 2016 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

123 S. High St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Belair RdAug 8, 1915

20-UNDERTAKER

ADDRESS

S. Linn... Belair

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087303

HEALTH DEPARTMENT—CITY OF BALTIMORE

120

087303

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Shakespeare St.)

2-FULL NAME

(1630 Shakespeare St.)—John Hopkins Hosp

Mollie Sulewska

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No. 1630 Shakespeare St.)

St.; 22 yrs. 4 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

September

1892

7-AGE

42

11

mos.

ds.

If LESS than 1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE
(State or country)

Poland, Russia

PARENTS

10-NAME OF FATHER

William Gardiza

11-BIRTHPLACE OF FATHER
(State or country)

Poland

12-MAIDEN NAME OF MOTHER

Anna Priskowska

13-BIRTHPLACE OF MOTHER
(State or country)

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wagpie Grochowska

(Address)

1630 Shakespeare St.

15-

AUG 8 - 1915

Charles M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August

6

1915

17-

I HEREBY CERTIFY, That I attended deceased from August 5, 1915, to, Aug. 6, 1915,

that I saw her alive on Aug. 6, 1915, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with hypertension

Contributory
(SECONDARY)

Pericarditis

(Signed),

Wm. A. Hodge

Aug. 6, 1915

[Address] John Hopkins Hospital

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death, 24 ds. in the State, yrs. mos. ds.

Where was disease contracted, Baltimore, Md.

Former or usual residence 1630 Shakespeare St., Baltimore, Md.

19-PLACE OF BURIAL OR REMOVAL

St. Stanislaus

DATE OF BURIAL

Aug

1915

20-UNDERTAKER

M. F. Wadsworth

ADDRESS

705 S. Ann St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widowed

6-DATE OF BIRTH

1843 (Month) (Day) (Year)

7-AGE

72 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Wales

10-NAME OF FATHER

John Davies

11-BIRTHPLACE OF FATHER (State or country)

Wales

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or country)

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 7, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 6 - 1915, to Aug 7 - 1915, that I saw him alive on Aug 7, 1915, and that death occurred, on the date stated above, at 9:40 P.M. The CAUSE OF DEATH* was as follows:

Acute Pericardial death in degeneration about 6 days

Contributory (SECONDARY)

(Signed)

Aug 7, 1915 (Address) 1107 Whelan St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathlamet

Aug 10, 1915

20-INTERURER

ADDRESS

H. Sander Lous

1701 E. Balt St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—5-19-13—M. & T.—500 Bks. *James Russell* 087305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *653 Gutman Ave* ST. *92* WARD)

2-FULL NAME *James Russell*

(Residence in Baltimore: No. *653 Gutman Ave* St.; *70* yrs., *0* mos. *0* ds.)

REGISTERED NO. C. (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-STATUS, *Single*
MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, *Don't know*, 1 (Month) (Day) (Year)

7-AGE, *75* yrs., *0* mos., *0* ds. 11-LESS than 1 day. hrs. or min.?

8-OCCUPATION: *Formerly Superintendent*
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer) *Male County*

9-BIRTHPLACE, (State or Country), *New Orleans La*

PARENTS.

10-NAME OF FATHER, *John Russell*

11-BIRTHPLACE OF FATHER (State or Country), *Scotland*

12-MAIDEN NAME OF MOTHER, *M. Hall*

13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *John Russell*
(Address) *653 Gutman Ave*

15-Filed *AUG 8* 1915 *Celluclear* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 5*, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 22* 1915, to *August 5* 1915, that I saw him alive on *August 5* 1915, and that death occurred, on the date stated above, at *12 P. m.*

The CAUSE OF DEATH* was as follows:
Paralysis due to apoplexy
July 22 to August 5 1915

(Duration) yrs. mos. ds.

CONTRIBUTORY... *Chronic Bright's*
(Secondary) *Heart Disease*
Valvular (Duration) yrs. mos. ds.

(Signed) *George E. Rogers* M. D.
August 7 1915. (Address) *Hamilton Hall*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Greenmount Cemetery* DATE OF BURIAL, *August 8* 1915

20-UNDERTAKER, *George J. Reuth* ADDRESS, *1735 Haysford Ave*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Baltimore City Jail*)

2-FULL NAME

(Residence in Baltimore: No. *Unknown (Came from Norfolk Va)*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds. *Unknown*

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH,

Unknown

1894

(Month)

(Day)

(Year)

7-AGE,

21

YRS.

mos.

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

General

9-BIRTHPLACE,

(State or Country),

Virginia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Record of Baltimore Jail

(Address)

15-

Filed *Aug 8 - 1915*

191

Charles M. Sinclair

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August

3rd

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH was as follows:

Pulmonary Tuberculosis

(Duration) *9* yrs. *9* mos. *9* ds.

CONTRIBUTORY

(Secondary)

(Duration) *7* yrs. *9* mos. *9* ds.

(Signed)

Wm M D Savage M. D.

(Coroner)

Aug 7

1915 (Address) *1724 Madison Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

9 yrs. *9* mos. *9* ds.

In the

Unknown

State

9 yrs. *9* mos. *9* ds.

Where was disease contracted, if not at place of death?

Unknown

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Sacred Heart

DATE OF BURIAL,

8/9 *1915*

20-UNDERTAKER

Chas P. Evans & Son 118 W Mt Royal Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087307 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE (No. *Wernyman's An Family St.* WARD) 15

2. FULL NAME

Mary Francis Rehm

(Residence in Baltimore: No. *Wernyman's An Family St.* yrs. mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6. DATE OF BIRTH *January 7th, 1886*
(Month) (Day) (Year)

7. AGE *29* yrs. mos. ds. or min. If LESS than 1 day, hrs.

8. OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
None

9. BIRTHPLACE (State or country) *Baltimore County Md*

10. NAME OF FATHER *Geo. A. Rehm*

11. BIRTHPLACE OF FATHER (State or country) *Baltimore Md*

12. MAIDEN NAME OF MOTHER *Catherine Bauer*

13. BIRTHPLACE OF MOTHER (State or country) *Baltimore Md*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Geo. A. Rehm*

(Address) *Wernyman's Lane*

15. *AUG 8 - 1915*
Filed *Charles M. Surdick* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug. 6 - 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 1 - 1915*, to, *Aug 6 - 1915*, that I saw her alive on *Aug 6 - 1915*, and that death occurred on the date stated above, at *7-30 P.m.* The CAUSE OF DEATH* was as follows:

"Tuberculosis." Long years' Suffering as Attended by Dr. C. E. Lister since Apr. 1915 until one week before death.
(Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) *H. G. Prestes* M. D. *Aug 7 - 1915* (Address) *634 G. Avenue*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Cathedral Cemetery Aug 9 - 1915

20. UNDERTAKER ADDRESS

F. B. Kippert 2238 E. 16 Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Union Protestant Infirmary

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Division St. 14

WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Edward L. Shipley

(Residence in Baltimore: No.

Eldersburg Md. C.P.

St.;

yrs.

mos. 13 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

, 1872

(Month)

(Day)

(Year)

7-AGE,

43 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

Maryland

10-NAME OF FATHER,

Henry B Shipley

11-BIRTHPLACE OF FATHER
(State or Country).

Maryland

12-MAIDEN NAME OF MOTHER

Susie Biddinger

13-BIRTHPLACE OF MOTHER
(State or Country).

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

A. Sheer

(Address)

Sykesville, Md.

15-

Filed

1915

191

Chas M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 8, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 26 1915, to Aug 8 1915,

that I saw him alive on Aug 8 1915,

and that death occurred, on the date stated above, at 5.27 am.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Nephritis acute

(Duration) yrs. mos. 4 ds.

(Signed) Edmund G. Davis M. D.

, 191... (Address) U.P.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death yrs. mos. 13 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Sykesville Md.

Former or usual residence Sykesville Md.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Freedom Md. Aug 1, 1915

20-UNDERTAKER ADDRESS

Jas. R. Meier Sykesville Md.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87309

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87309

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Foot of Hecht St* ST. *22* WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. *507 Benjamin Alley* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

40 yrs. *—* mos. *—* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer). *General*

9-BIRTHPLACE, (State or Country).

Calvert Co Md

10-NAME OF FATHER,

Joseph Thomas

11-BIRTHPLACE OF FATHER (State or Country).

Calvert Co Md

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *ella Thomas*

(Address) *1124 W. 11th*

15-

AUG 9 - 1915

Filed *1915*

HARRY O. ANDREWS
KARL F. FORMIS
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 6, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held as *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

inquest and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fell from beam
Accidental
(Duration) *—* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.

(Signed) *Edw. J. Smith* M. D.

(Coroner)

Aug 8, 1915 (Address) *511 North*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death? *—*

Former or usual residence *—*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Calvert Co Md

Aug 9, 1915

20-UNDERTAKER

ADDRESS

John Brown & Son
108 N. Montross
Landings Avenue, River View, Md

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Tolchester Wharf Light St ST. 169 WARD) REGISTERED No. C
2-FULL NAME Lewis Jackson (Known as Levin Ennis)
(Residence in Baltimore: No. 124 Perry St St. 1 yrs., 1 mos., 1 da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <u>Male</u>	4-COLOR OR RACE, <u>Colored</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Single</u>
6-DATE OF BIRTH, <u>Unknown</u> / <u>1</u> (Month) (Day) (Year)		
7-AGE, <u>50</u> yrs. <u>1</u> mos. <u>1</u> da.		8-LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <u>Deck Hand</u> (b) General nature of industry, business, or establishment in which employed (or employer), <u>Steamer Louise</u>		
9-BIRTHPLACE, (State or Country), <u>West River A A Co Md</u>		
PARENTS.	10-NAME OF FATHER, <u>Unknown</u>	
	11-BIRTHPLACE OF FATHER (State or Country), <u>Unknown</u>	
	12-MAIDEN NAME OF MOTHER <u>Unknown</u>	
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Unknown</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Morris Brown
(Address) 106 W. Montgomery St

15-
AUG 9 - 1915 HARRY O. ANDREWS,
Filed 191 Barrel Permit Clery
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,
Aug 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry
(Inquest, autopsy or inquiry.)
and that said deceased came to His death on the day stated above.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
(Duration) 1 yrs. 1 mos. 1 da.

CONTRIBUTORY (Secondary)
(Duration) 1 yrs. 1 mos. 1 da.
(Signed) Edmund M. D.
(Coroner)
Aug 8, 1915 (Address) 517 Scott St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death 1 yrs. 1 mos. 1 da. In the State 1 yrs. 1 mos. 1 da.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Chalk Point West River DATE OF BURIAL, Aug 10, 1915

20-UNDERTAKER C. L. Brown & Son ADDRESS 108 W. Montgomery

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 18.)

St.; yrs. 2 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

IF LESS than

1 day, — hrs.,

or — min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

HARRY O. ANDREWS,

Serial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

May 29, 1915, to, Aug. 7, 1915, that I saw him alive on Aug. 7, 1915, and that death occurred, on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows:

Tubercle of Lungs and Larynx

Contributory (SECONDARY)

(Signed)

August 7, 1915. (Address) U. S. Marine Hospital

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, — yrs. 2 mos. 8 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death? Unknown

Former or usual residence Unknown

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn Aug. 9, 1915

20-UNDERTAKER

ADDRESS

Chenoweth & Son Chestnut Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *104 S Howard St.* ST. *73* WARD)

2-FULL NAME *Katherine M. Jones*

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 18.)

(Residence in Baltimore: No. *1011 S Howard* St. *Life* yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Black* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Single*

6-DATE OF BIRTH *Aug 5 1890*
(Month) (Day) (Year)

7-AGE *45* yrs. mos. ds. or min. ? If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work *Domestic* (b) General nature of industry, business, or establishment in which employed (or employer) *Private Family*

9-BIRTHPLACE (State or country) *Baltimore*

PARENTS 10-NAME OF FATHER *Isiah Jones* 11-BIRTHPLACE OF FATHER (State or country) *Talbot Co.* 12-MAIDEN NAME OF MOTHER *Mary Bennett* 13-BIRTHPLACE OF MOTHER (State or country) *Norw. Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Mary Jones* (Address) *1011 S Howard St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Aug 6 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 1*, 1915, to, *Aug 6*, 1915, that I saw him alive on *July 1*, 1915, and that death occurred, on the date stated above, at *3:30 P.* m.

The CAUSE OF DEATH* was as follows:
Bright's Disease
(Duration) yrs. mos. ds.

Contributory (SECONDARY) *None* (Duration) yrs. mos. ds.
(Signed) *A. Edward Smith* M. D. *Aug 7 1915* [Address] *710 Light St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Mt. Auburn Ct* DATE OF BURIAL *Aug 9 1915*

20-UNDERTAKER *Wm. Brown* ADDRESS *108 W. Monument St.*

18- AUG 9 - 1915 HARRY O. ANDREWS, REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

C87314

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1937 W Fayette ST. W WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Knoop(Residence in Baltimore: No. 1937 W Fayette St. 60 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE White5-SINGLE, Widow
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH Not Known, 1836

(Month)

(Day)

(Year)

7-AGE 79

yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, Herman Poike11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Not Known13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Caroline Plempel(Address) 1937 W Fayette St

15-

AUG 9 - 1915

HARRY O. ANDREWS,

Filed.....

191.

Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH August 7, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from July 16th 1915, to August 7 1915, that I saw her alive on August 6th 1915, and that death occurred, on the date stated above, at 4³⁰ m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis(Duration) don't know yrs. — mos. — ds.CONTRIBUTORY (Secondary) naemia(Duration) 14 yrs. — mos. — ds.(Signed) John Hoff M. D.Aug 8....., 1915.(Address) 15 N. Monroe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park CemeteryDATE OF BURIAL AUG 9 - 191520-UNDERTAKER Geo. A. LerbyADDRESS Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8

C87315

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87315

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____)

2-FULL NAME

(Residence in Baltimore: No. _____)

Johns Hopkins Hosp.
Joseph Johnson
614 Jasper St.

ST.

WARD

120
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; _____ yrs. _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widower

6-DATE OF BIRTH

August 23, 1862

(Month)

(Day)

(Year)

7-AGE

52 yrs. 11 mos. 16 ds.

If LESS than 1 day, _____ hrs., _____ min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Model.

9-BIRTHPLACE
(State or country)

md.

10-NAME OF FATHER

Abraham Johnson

11-BIRTHPLACE OF FATHER
(State or country)

md.

12-MAIDEN NAME OF MOTHER

Rachel Cornish

13-BIRTHPLACE OF MOTHER
(State or country)

md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Phelps
Johns Hopkins Hosp.

15-

AUG 9 - 1915

HARRY O. ANDREWS,

Barial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 8, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from July 4, 1915, to Aug 8, 1915, that I saw him alive on Aug 8, 1915, and that death occurred, on the date stated above, at 6:10 a.m. The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration)

4 mos.

Contributory (SECONDARY)

None

(Duration)

yr.

mos.

ds.

(Signed),

Staubas Beene-Jones

Aug 8, 1915

[Address]

Johns Hopkins Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yr.

mos.

35

ds.

State

52

yr.

mos.

Where was disease contracted, if not at place of death?

Former or usual residence

614 Jasper St.

19-PLACE OF BURIAL OR REMOVAL

Mount Auburn

DATE OF BURIAL

August 10, 1915

20-UNDERTAKER

John H. Owens

ADDRESS

1222 Remond

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *1802 1/2 Hanover St.*)

2-FULL NAME

Geo. V. Green

(Residence in Baltimore: No. *1802 1/2 Hanover St.*)

REGISTERED No. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH

Aug 7, 1914

7-AGE

1 yrs. 1 mo. 1 da. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE, (State or Country)

Md. (City)

10-NAME OF FATHER

Wm E Green

11-BIRTHPLACE OF FATHER

Md.

12-MAIDEN NAME OF MOTHER

Charlotte Barr

13-BIRTHPLACE OF MOTHER

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm E Green*

(Address) *1802 1/2 Hanover St.*

15-

AUG 9 - 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 8, 1915

17- I HEREBY CERTIFY, That I attended deceased from *Aug 1, 1915*, to *Aug 8, 1915*, that I saw him alive on *Aug 7, 1915*, and that death occurred, on the date stated above, at *4 A* m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

CONTRIBUTORY (Secondary)

(Signed) *Wm E Green* M. D.
Aug 8, 1915 (Address) *1802 1/2 Hanover St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London PK Cem

DATE OF BURIAL

Aug 9, 1915

20-UNDERTAKER

J. F. Green

ADDRESS

39 E. Front.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1437 Patapasco* ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME

Margaret Eastner(Residence in Baltimore: No. *1437 Patapasco* St.;

yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Jan 22, 1885
(Month) (Day) (Year)

7-AGE,

30 yrs. 6 mos. 6 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*

9-BIRTHPLACE, (State or Country),

Md. (City)

10-NAME OF FATHER,

John Koff

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Eastner*(Address) *1437 Patapasco*

15-

Filed

AUG 9 - 1915

HARRY O. ANDREWS,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 8, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*April 13, 1915, to Aug 8, 1915*that I saw her alive on *Aug 7, 1915*and that death occurred, on the date stated above, at *2:45 P.M.*

The CAUSE OF DEATH* was as follows:

Cancer of Uterus and Vagina with vesico-vaginal fistula (blended diagnosis).

(Duration) yrs. mos. ds.

CONTRIBUTORY* *Infection*

(Secondary)

Adenitis (Duration) yrs. mos. ds.(Signed) *Mr. Cornhill*

M. D.

Aug 9, 1915 (Address) *1704 Madison Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*London Park Cem.**Aug 11, 1915*

20-UNDERTAKER

ADDRESS

*J. F. McCall**37 E. Fort Ave*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87318

C87318

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1307 E. Federal St.* ST. *9* WARD)

REGISTERED NO. C

2-FULL NAME

Mary C. Dreehler

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1307 E. Federal St.* St. *9* yrs. *10* mos. *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED,

(Write the word.)

Widower

6-DATE OF BIRTH,

Sept. 28th, 1850

7-AGE,

64 yrs. 10 mos. 11 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Balto.

10-NAME OF FATHER,

Geo. Ritter

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Mary Yenter

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary C. Dreehler

(Address)

1307 E. Federal St.

15-

Filed

AUG 9 - 1915

191

HARRY O. ANDREWS,

MARIAL FORMERLY

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 8, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Aug 5 1915, to Aug 8 1915,*that I saw her alive on *Aug 7 1915,*and that death occurred, on the date stated above, at *4 a.m.*

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Mitral Regurgitation. Acute Indigestion.

(Duration).....yrs.....mos.....3.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....*P. P. Carman*.....M. D.*Aug 9, 1915.* (Address).....*1201 W. Fayette*.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Green Mount Cemetery Aug 10, 1915

20-UNDERTAKER

ADDRESS

E. M. Mitchell & Co. 1201 W. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87319

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87319

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Elizabeth Home* ST. WARD)

2-FULL NAME *Louis Melinger*

(Residence in Baltimore: No. *St. Paul St.* St.; yrs. *5* mos. *—* ds.)

REGISTERED No. C. *29*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

colored

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

Dec. 1, 1914

7-AGE

8 yrs. *7* mos. *—* ds. or *1* day, *—* hrs., *—* min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Washington D. C.

10-NAME OF FATHER

Louis R. Melinger

11-BIRTHPLACE OF FATHER
(State or country)

La.

12-MAIDEN NAME OF MOTHER

Ruth Bayard

13-BIRTHPLACE OF MOTHER
(State or country)

Washington D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

her mother Mr. Mildred

(Address)

St. Elizabeth Home

15-AUG 9 - 1915

Filed *191*

HARRY O. ANDERSON,
Baptist Minister

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 7, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *Mar 3, 1915*, to *Aug 7, 1915*, that I saw him alive on *Aug 7, 1915*, and that death occurred, on the date stated above, at *7:10* p.m. The CAUSE OF DEATH* was as follows:

Acute infectious Tuberculosis

(Duration) yrs. *14* mos. *—* ds.

Contributory
(SECONDARY)

Glandular T. B.

(Duration) yrs. *14* mos. *—* ds.

(Signed) *Edgar B. Friedmann* M. D.

Aug 8, 1915 [Address] *1616 Linden Ave*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. *5* mos. *—* ds. In the State yrs. *5* mos. *—* ds.

Where was disease contracted, If not at place of death *St Elizabeth Home*

Former or usual residence *St Elizabeth Home*

19-PLACE OF BURIAL OR REMOVAL

Cathedral Cemetery

DATE OF BURIAL

Aug 9th, 1915

20-UNDERTAKER

Geo. H. Holland

ADDRESS

517 Robert St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28

C87320

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

Apr 11, 1913 (Month) (Day) (Year)

7-AGE

2 yrs. 3 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Home

9-BIRTHPLACE (State or country)

Balto -

10-NAME OF FATHER

W. H. Hume

PARENTS

11-BIRTHPLACE OF FATHER (State or country)

Dist. Knox

12-MAIDEN NAME OF MOTHER

Flora Hargard

13-BIRTHPLACE OF MOTHER (State or country)

Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Hume (Address) 9 W. Preston St.

15-

AUG 9 - 1915

HARRY O. ANDREWS

Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 7, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 6, 1915, to Aug 7, 1915

that I saw him alive on Aug 6, 1915

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory (SECONDARY)

(Duration) 4 mos. ds.

(Signed)

(Duration) yrs. 1 mos. ds.

W. H. Hume (Address) 9 W. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Samuel Clem

DATE OF BURIAL

Aug 9, 1915

20-UNDERTAKER

Samuel Carlson

ADDRESS

916 Penna ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87321

C87321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

703 1/2 W. Saratoga

ST. 4 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

James Sisco (Sisco)

Residence in Baltimore: No.

703 1/2 W. Saratoga

St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH.

August, 1868
(Month) (Day) (Year)

7-AGE.

47

If LESS than 1 day, hrs., or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Waiter
Hotel

9-BIRTHPLACE, (State or Country).

Baltimore

10-NAME OF FATHER.

Chas Sisco

11-BIRTHPLACE OF FATHER (State or Country).

Md.

12-MAIDEN NAME OF MOTHER

Julia Sisco

13-BIRTHPLACE OF MOTHER (State or Country).

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Annie M. Sisco

(Address)

703 1/2 W. Saratoga

15-

AUG 9 - 1915

Filed

191

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 6, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1915, to Aug 6, 1915,
that I saw him alive on Aug 6, 1915,

and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Disease

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

Heart Failure

(Duration) yrs. 8 mos. ds.

(Signed) Charles H. Harlan, D.

Aug 8, 1915. (Address) 712 S. Sharp St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL

Buried in

Aug 9, 1915

20-UNDERTAKER

Sam L. E. Newshy

ADDRESS

578 Biddle

item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87322

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *1530 So Charles* ST. *73* WARD)

2-FULL NAME *Mollie S. Heim*

(Residence in Baltimore: No. *1530 So Charles* St.; *20* yrs. *2* mos. *23* ds.)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and RW out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *May 15 1895*
(Month) (Day) (Year)

7-AGE *20* yrs. *2* mos. *23* ds. If LESS than 1 day, hrs., min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *Seamstress*
(b) General nature of industry, business, or establishment in which employed (or employer) *8 hirt factory*

9-BIRTHPLACE
(State or country)

Balto. Md.

10-NAME OF FATHER

Charles A. Heim

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Matilda Truhe

13-BIRTHPLACE OF MOTHER
(State or country)

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Heim

(Address)

1530 So Charles St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Aug 7 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *July 26*, 1915, to *Aug 7*, 1915, that I saw him alive on *Aug 7*, 1915, and that death occurred, on the date stated above, at *10 A.M.*

The CAUSE OF DEATH* was as follows:

acute Pericardial dilatation

Contributory (SECONDARY)

Typhoid Fever (Duration) yrs. mos. *2 hrs.*

(Signed)

J. F. Hawley M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Western Cemetery

DATE OF BURIAL

Aug 9th 1915

20-UNDERTAKER

W. F. M. Flynn

ADDRESS

1422 Light St.

15-AUG 9 - 1915

HARRY O. ANDREWS,

Notarial Permit Clerk.

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *808 N. Dallas* ST.; *10* WARD)

FULL NAME

Residence in Baltimore: No. *808 N. Dallas*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

Caucasian

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

married

6-DATE OF BIRTH,

Unknown, *1860*
(Month) (Day) (Year)

7-AGE,

55

..... yrs. mos. ds.

If LESS than 1 day,

..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work..... *Laborer*

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)..... *General*9-BIRTHPLACE,
(State or Country),*Unknown*10-NAME OF
FATHER,*Unknown*11-BIRTHPLACE
OF FATHER
(State or Country),*Unknown*12-MAIDEN NAME
OF MOTHER*Unknown*13-BIRTHPLACE
OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)..... *George Dorsey*(Address)..... *808 N. Dallas St.*

15-

AUG 9 - 1915

HARRY O. ANDREWS,

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 7, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 10, *1915*, to *Aug. 7*, *1915*,that I saw him alive on *Aug. 6*, *1915*,and that death occurred, on the date stated above, at *4:20* m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

.....

..... (Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)*General debility*

..... (Duration)..... yrs. mos. ds.

(Signed).....

..... M. D.

Aug. 7, *1915* (Address) *611 N. Carroll St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Mary's Cemetery**Aug. 9*, *1915*

20-UNDERTAKER

ADDRESS

*Robert A. Elliott**St. Mary's Ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87321

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87321

CERTIFICATE OF DEATH

1-PLACE OF DEATH

28

REGISTERED NO. C

CITY OF BALTIMORE (No.

3500 Edmondson Ave

ST.

16

WARD)

2-FULL NAME

Mrs. Hermoine Minnie Mattes

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

3500 Edmondson Ave

St.

36

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

March

23, 1860

(Month)

(Day)

(Year)

7-AGE

64

yrs.

4

mos.

14

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Germany

10-NAME OF FATHER

John Bruney

11-BIRTHPLACE OF FATHER

(State or country)

Germany

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Minnie F. Gross

(Address)

3500 Edmondson Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August

7

1915

(Month)

(Day)

(Year)

17.

I HEREBY CERTIFY, That I attended deceased from

July

30

1915

to

Aug

7

1915

that I saw her alive on Aug 7

and that death occurred, on the date stated above, at 1:50 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)

2

yrs.

mos.

ds

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

Mary F. Voeglein

M. D.

Aug 7, 1915

(Address)

1028 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

In the

ds. State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Cemetery

Aug 13, 1915

20-UNDERTAKER

ADDRESS

Relf. F. Turner

1842 N. Dwyer

AUG 9 - 1915

HARRY O. ANDERSON,

Registrar

REGISTRAR

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

087325
PLACE OF DEATH
CITY OF BALTIMORE: (No. *1301 N Rose* ST.: *6* WARD) (If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)
FULL NAME *Carrie Elizabeth Lewis*
(Residence in Baltimore: No. *1301 N Rose St.* St. *16* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH *December 19, 1884*
(Month) (Day) (Year)

7-AGE, *31* yrs. *7* mos. *19* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). *Washington DC*

10-NAME OF FATHER, *Samuel Strong*

11-BIRTHPLACE OF FATHER (State or Country). *Scotland*

12-MAIDEN NAME OF MOTHER *Don't Know*

13-BIRTHPLACE OF MOTHER (State or Country). *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Lewis*

(Address) *1301 N. Rose St.*

15- AUG 9 - 1915
Filed..... 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Aug 7, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 3* 1915, to *Aug 7* 1915, that I saw her alive on *Aug 6* 1915, and that death occurred, on the date stated above, at *7:30* a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis
.....
..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Pleurisy*

..... (Duration) yrs. mos. ds.

(Signed) *Dr. Herzog* M. D.

Aug 7....., 1915 (Address) *1301 N. Rose St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL, *Baltimore Cent.* *Aug. 12, 1915.*

20-UNDERTAKER ADDRESS *Relf L. Turner* *1442 N. Brady*

WRITE CLEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *612 E. Biddle*)
2-FULL NAME *Frederick G. Herbert*
(Residence in Baltimore: No. *612 E. Biddle*)

79
10 ST. WARD
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
St.; yrs., *64* mos. *11* da.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
6-DATE OF BIRTH *Sept. 16th 1850*
(Month) (Day) (Year)
7-AGE *64* yrs. *11* mos. *8* da. IF LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Tailor Merchant*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country), *Germany*

PARENTS.
10-NAME OF FATHER, *John G. Herbert*
11-BIRTHPLACE OF FATHER, (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER, *Margaret Koch*
13-BIRTHPLACE OF MOTHER, (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Mrs. John H. Rowe*
(Address) *612 E. Biddle*

15- AUG 9 - 1915
Filed..... 191. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *August 8th 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquiry* (Inquest, au- today or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Valvular Heart-disease
(Duration) *3* yrs. mos. da.

CONTRIBUTORY (Secondary) (Duration) *3* yrs. mos. da.
(Signed) *Moses M. Savage* M. D.
(Coroner.)
Aug. 8, 1915 (Address) *1729 N. Division*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.... yrs. mos. da. In the State.... yrs. mos. da.
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer* DATE OF BURIAL, *Aug. 11, 1915*
20-UNDETAKEE *Robt. L. Turner* ADDRESS *1442 N. Bldg.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *8*)ST.; *11* WARD)

REGISTERED NO. C

2-FULL NAME

Baby Bryan

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.)

St.; yrs., mos., ds.) *2*

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*colored*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

IF LESS than 1 day,

2 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....?

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),*Batts, Md.*

10-NAME OF FATHER,

*Joseph Lane*11-BIRTHPLACE OF FATHER
(State or Country),*Md.*

12-MAIDEN NAME OF MOTHER

*Laura Bryan*13-BIRTHPLACE OF MOTHER
(State or Country),*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

J. B. Warner M.D.

(Address).....

Md. Gen. Hospital

15-AUG 9 - 1915

Filed.....

191.....

HARRY O. ANDERSON

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 7 1915, to *Aug. 7* 1915,that I saw him alive on *Aug. 7* 1915,

and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:

congenital atelectasis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)*Prolonged labor*

(Duration)..... yrs..... mos..... ds.

(Signed) *D. S. Torrance M.D.**8/8/15*, 1915. (Address) *Md. Gen. Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos. *2* hrs. ds. In the State..... yrs..... mos. *2* hrs. ds.Where was disease contracted? *?*
if not at place of death?Former or usual residence *?*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

COLLEGE OF P. & S. *AUG 9 1915*

20-UNDERTAKER

ADDRESS

FOR ANATOMICAL PURPOSES

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hosp.* ST. *18* WARD)

2-FULL NAME

(Residence in Baltimore: No. *804 W Saratoga* St.; *0* yrs., *0* mos., *0* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, DIVORCED, WIDOWED

Single
(Write the word.)

6-DATE OF BIRTH,

8-2-1915
(Month) (Day) (Year)

7-AGE,

0 yrs., *0* mos., *4* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Leander S. Arnold

11-BIRTHPLACE OF FATHER (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Bessie Poole

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(Address).....

15-

AUG 9 - 1915

Filed.....

*HARRY O. ANDREWS,**1901 E. 1st St. Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

8-6-1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

8-2-1915, to *8-6-1915*that I saw him alive on *8-6-1915*and that death occurred, on the date stated above, at *1:15 A.M.*

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis
+ Pneumonia
(Duration) *0* yrs., *0* mos., *4* ds.

CONTRIBUTORY (Secondary)

(Duration) *0* yrs., *0* mos., *4* ds.

(Signed).....

Harry O. Andrews M. D.
101... (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *2* yrs., *0* mos., *4* ds. In the State *4* yrs., *0* mos., *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

804 W Saratoga St

19-PLACE OF BURIAL OR REMOVAL,

COLLEGE OF P. & S.

DATE OF BURIAL,

AUG. 9. 1915

20-UNDERTAKER

Health Commissioner

ADDRESS

FOR ANATOMICAL PURPOSES.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No.....

ST.:..... WARD)

2-FULL NAME

(Residence in Baltimore: No.....

St.: 15 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Single*
~~MARRIED~~
~~WIDOWED~~
~~OR DIVORCED~~
(Write the word)

6-DATE OF BIRTH *March 13th 1857*
(Month) (Day) (Year)

7-AGE *64* yrs. *4* mos. ds. or min.?
If LESS than 1 day, hrs., min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *France*

PARENTS
10-NAME OF FATHER *Guillaume Jouve*
11-BIRTHPLACE OF FATHER (State or country) *France*
12-MAIDEN NAME OF MOTHER *Jeanne Chareyron*
13-BIRTHPLACE OF MOTHER (State or country) *France*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Sister Benedict*
(Address) *Little Sisters of the Poor*

15- *Chas M. Inclair*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August 8* 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *no record* 1915
that I saw him alive on *August 7* 1915
and that death occurred, on the date stated above, at *5 a.* m.
The CAUSE OF DEATH* was as follows:

Myocardial degeneration

Unknown (Duration) yrs. mos. ds.

Contributory (SECONDARY) *Extreme heat*

(Duration) yrs. mos. ds.

Aug 8 1915 (Address) *1133 Valley n*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *15* yrs. *6* mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? *Unknown*

Former or usual residence *Little Sisters of the Poor*

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cathedral *Aug 10* 1915

20-UNDERTAKER ADDRESS

H. C. Wiedefeld 914 Green

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87330

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87330

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1823 Frederick Ave* ST. *20* WARD)

2-FULL NAME *Elias Lührer*

(Residence in Baltimore: No. *1823 Frederick Ave* St. *20* WARD)

REGISTERED NO. C. *120*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widower

6-DATE OF BIRTH

Dec

24 18*46*

(Month)

(Day)

(Year)

7-AGE

68

yr.

7

mos.

14

ds.

or

1

day,

hrs.

min.?

If LESS than

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired Shoe Merchant

9-BIRTHPLACE

(State or country)

Germany

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER

(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Lührer

(Address)

1823 Frederick Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 7, 191*5*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 31, 191*5*, to, *Aug 7*, 191*5*,

that I saw him alive on *Aug 6*, 191*5*,

and that death occurred, on the date stated above, at *5:30 a.m.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration)

over

7

ds.

Contributory
(SECONDARY)

(Duration)

1

1

ds.

(Signed),

Henry C. Chiles

M. D.

Aug 7, 191*5*

(Address)

1203 N. Fayette St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yr.

mos.

ds.

In the

yr.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Balto. Cemetery

Aug 10, 191*5*

20-UNDERTAKEN

ADDRESS

Geo. L. Schmalz & Bro

2101 Frederick Ave

REGISTRAR

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2132 Drum Hill Ave St. 14 WARD)

2-FULL NAME

Elizabeth Ethel Terrell

(If death occurred in a hospital or institution, give its NAME instead of street and number and list out No. 18.)

(Residence in Baltimore: No. 2132 Drum Hill Ave St. 4 yrs. 4 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

F

4-COLOR OR RACE

C

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

July 11, 1906
(Month) (Day) (Year)

7-AGE

9 yrs. 27 mos. 4 ds. or min. 2

If LESS than
1 day, hrs. 2

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

School Child

9-BIRTHPLACE
(State or country)

Essex Co., Virginia

10-NAME OF FATHER

James Terrell

11-BIRTHPLACE OF FATHER
(State or country)

Essex Co., Va.

12-MAIDEN NAME OF MOTHER

Maria Mann

13-BIRTHPLACE OF MOTHER
(State or country)

Essex Co., Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maria Terrell

(Address)

2132 Drum Hill Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 8, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

July 10, 1915, to, Aug 8, 1915,

that I saw her alive on Aug 8, 1915,

and that death occurred, on the date stated above, at 3:10 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. 15 mos. 15 ds.

Contributory
(SECONDARY)

Typhoid Fever

(Duration) yrs. 1 mos. 1 ds.

(Signed) J. N. Mays

Aug 9, 1915 [Address] 1209 Presb.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. 4 mos. 4 ds. In the State yrs. 4 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

McGowan

DATE OF BURIAL

Aug 10, 1915

20-UNDERTAKER

Wm. H. Chase & Son

ADDRESS

1400 Mosher

15-

Aug 8, 1915

Chas. M. Sinclair

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

720 W. German

ST.;

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John Nicholas Evans.

(Residence in Baltimore: No.

720 W. German St

St.; 25 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

April 5th, 1890.

(Month)

(Day)

(Year)

7-AGE,

25 yrs., 4 mos., ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

Straw hat
Blocker.

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Joseph A. Evans.

11-BIRTHPLACE

OF FATHER

(State or Country),

Plum Point.

12-MAIDEN NAME

OF MOTHER

Sarah E. Rollins.

13-BIRTHPLACE

OF MOTHER

(State or Country),

Baltimore Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Joseph A. Evans.

(Address),

720 W. German St.

15-

AUG 9 - 1915

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 7, 1915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

January 1915, to Aug 7, 1915,

that I saw him alive on Aug 7, 1915,

and that death occurred, on the date stated above, at 4:05 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) 2 yrs., 4 mos., ds.

CONTRIBUTORY

(Secondary)

(Duration) 1 yrs., 1 mos., ds.

(Signed) E. H. McClure M. D.

Aug 8, 1915. (Address) 24 W. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL

EBENEZER CEMETERY

CHASE BALTIMORE CO MD.

DATE OF BURIAL,

AUGUST 12, 1915.

McClure &

ADDRESS

20-UNDERTAKER

HENRY W. JENKINS & SONS CO ORCHARD STS.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87333

C87333

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 N. Port ST. 1st WARD)

2-FULL NAME

(Residence in Baltimore: No. 503 N. Port St.; ..yrs., ..mos., ..da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

July 15, 1883
(Month) (Day) (Year)

7-AGE,

32 yrs., ..mos., ..da.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Ship- Carpenter

9-BIRTHPLACE, (State or Country),

Ireland

10-NAME OF FATHER,

Michael Flaherty

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Donohue

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mar. J. Flaherty(Address) 503 N. Port St.

15-

AUG 8 1915 1915 Blushclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 1 1914, to Aug 7 1915,that I saw him alive on Aug 6 1915,and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiparesis
(Clinical Diagnosis)

..... (Duration) ..yrs.mos.da.

CONTRIBUTORY (Secondary)

..... (Duration) ..yrs.mos.da.

(Signed) P. J. Sullivan M. D.Aug 7, 1915. (Address) 2601 E. Mt. Vernon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..yrs.mos.da. In the State ..yrs.mos.da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Patrick's Cemetery

DATE OF BURIAL,

Aug 10, 1915

20-UNDERTAKER

John A. Moran

ADDRESS

Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *105* ST.; *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *311 Lyson St* St.; *1* yrs., *1* mos., *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

Nov. 10, 1911
(Month) (Day) (Year)

7-AGE,

5 yrs., *8* mos., *18* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Ind.

PARENTS.

10-NAME OF FATHER

Geo. Yates

11-BIRTHPLACE OF FATHER (State or Country),

Va

12-MAIDEN NAME OF MOTHER

Rebecca Smith

13-BIRTHPLACE OF MOTHER (State or Country),

Wld.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo. & Mary Hosp.*(Address) *Colbert St*

15-

AUG 9 1915

191

W. H. H. H. H.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 7, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 19, 1915*, to *Aug 7, 1915*, that I saw him alive on *Aug 7, 1915*, and that death occurred, on the date stated above, at *3:50 P* m.

The CAUSE OF DEATH* was as follows:

Bacter-Colitis(Duration) *1* yrs., *1* mos., *1* ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs., *1* mos., *1* ds.(Signed) *Edward M. Smith*

M. D.

Aug 7, 1915 (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *19* yrs., *1* mos., *1* ds. In the *Ind.* State *Ind.*Where was disease contracted, if not at place of death? *311 Lyson St*Former or usual residence *311 Lyson St*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*COLLEGE OF P. & S.**AUG 9 1915*

20-UNDERTAKER

ADDRESS

FOR ANATOMICAL PURPOSES.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number; and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
8 hrs. or... min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country),10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

AUG 9 - 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on... and that death occurred, on the date stated above, at... m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY,
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signature)..... H. D.

(Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death..... In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

COLLEGE OF P. & S.

AUG - 9 - 1915

20-UNDERTAKER

ADDRESS

Commissioner Health.

Per, Wm E. WOODALL.

FOR ANATOMICAL PURPOSES.

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087337 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infirmary*ST.: *14*

WARD)

REGISTERED NO. C

2-FULL NAME

George Jones

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

(Residence in Baltimore: No. *St. Vincent's Infant Asylum*St.; yrs. *3* mon. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH.

April
(Month)*22*
(Day)*1915*
(Year)

7-AGE.

3 yrs. *3* mon. *15* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.

(State or Country).

Maryland

PARENTS.

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER

(State or Country).

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

Filed *9161* *511*

191

W. H. McClair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August
(Month)*7*
(Day)*1915*
(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1st 1915, to *Aug. 7th* 1915,that I saw him alive on *Aug. 7th* 1915,and that death occurred, on the date stated above, at *10:45 P.M.*

The CAUSE OF DEATH* was as follows:

*Malnutrition and
Mal-assimilation*(Duration) yrs. *2* mos. *15* ds.CONTRIBUTORY
(Secondary)*Tuberculosis*(Duration) yrs. *1* mos. *15* ds.(Signed) *J. P. Corliss* M. D.*Aug. 8, 1915.* (Address) *615 Columbian Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VICARIOUS CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *3* mon. *15* ds. In the State yrs. *3* mon. *15* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Cathedral**Aug. 9, 1915*

20-UNDERTAKER

ADDRESS

M. Fahay & Sons 606 Lafayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Vincent's Chft Asy.* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Julia Harris*(Residence in Baltimore: No. *St Vincent's Chft Asylum* St.; yrs. *9* mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH.

April 16, 1915
(Month) (Day) (Year)

7-AGE.

9 yrs. 2 mos. 23 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*England*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St Vincent's*(Address) *1401 E. Union St.*

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 8, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *August 5, 1915*, to *August 8, 1915*, that I saw her alive on *August 8, 1915*, and that death occurred, on the date stated above, at *9:00 P. m.*

The CAUSE OF DEATH* was as follows:

Gastro-enteritis(Duration) *9* yrs. *3* mos. *23* ds.CONTRIBUTORY
(Secondary)(Duration) *9* yrs. *3* mos. *23* ds.(Signed) *J. E. Toulson* M. D.*Aug. 9, 1915* (Address) *615 Columbia Ave.*
per John A. M. Apple

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *9* mos. *23* ds. In the State yrs. *9* mos. *23* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*Cathedral**Aug. 9, 1915*

20-UNDERTAKER

ADDRESS

*M. Fahay & Sons**604 Lafayette*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *420 S. Regester* ST. *2* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)
2-FULL NAME *Alex Sliwaka*
(Residence in Baltimore: No. *420 S. Regester* St.; yrs. *7* / mos. *19* ds. *20*)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>Single</i> (Write the word.)
6-DATE OF BIRTH, <i>December 21, 1913</i> (Month) (Day) (Year)		
7-AGE, <i>1</i> yrs. <i>7</i> mos. <i>19</i> ds.		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work... <i>None</i> (b) General nature of industry, business, or establishment in which employed (or employer).....		
9-BIRTHPLACE, (State or Country), <i>Baltimore</i>		
PARENTS.	10-NAME OF FATHER, <i>Alex Sliwaka</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Russia</i>	
	12-MAIDEN NAME OF MOTHER <i>Annie Boluski</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Russia</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alex Sliwaka*
(Address) *420 S. Regester St*

15-

Filed *AUG 9 - 1915* *Edw. M. Munder*
101. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 8, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.
(Signed) *D. W. Jones* M. D.
(Coroner.)
Aug 9, 1915 (Address) *3116 O'Donnell St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary

Aug 10, 1915

20-UNDERTAKER

ADDRESS

Jacob Ziatskowski *420 S. Regester*

13
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Johns Hopkins Hospital* ST. 5 WARD)

2-FULL NAME *Evelyn H. Johnson*

(Residence in Baltimore: No. *612 N. Spring*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Child* (Write the word.)

6-DATE OF BIRTH, *June 6th, 1910* (Month) (Day) (Year)

7-AGE, *5* yrs., *2* mos., *3* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Child* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Ind.*

10-NAME OF FATHER, *Henry Johnson*

11-BIRTHPLACE OF FATHER (State or Country), *Ind.*

12-MAIDEN NAME OF MOTHER, *Altena Johnson*

13-BIRTHPLACE OF MOTHER (State or Country), *Richmond, Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Altena Johnson*

(Address) *612 N. Spring St.*

15-

Filed, *Aug 10 1915* 101 *Clas M. Sinclair*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 7th, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry* (Inquest, autopsy or inquiry.)

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns of 2nd degree over 2/3 of body caused by striking Catching fire (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Elijah Russell* M. D.

Aug 8 1915 (Address) *428 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *3 hours* in the of death yrs. mos. ds. State *5* yrs. *4* mos. *5* ds.

Where was disease contracted, if not at place of death?

612 N. Spring St.

Former or usual residence *612 N. Spring St.*

19-PLACE OF BURIAL OR REMOVAL, *Asbury Cem* DATE OF BURIAL, *Aug 10 1915*

20-UNDERTAKER, *Harry A. Voderberg* ADDRESS, *1725 Orleans St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — CITY OF BALTIMORE: (No. 1349 Carroll St ST.; 91 WARD) REGISTERED NO. C.....
 2-FULL NAME Lillie Mae Brown
 (Residence in Baltimore: No. 1349 Carroll St St.; 9 yrs., 7 mos., 7 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)
 6-DATE OF BIRTH, Nov. 1, 1914
 (Month) (Day) (Year)
 7-AGE, 9 yrs., 7 mos., 7 ds. If LESS than 1 day, ... hrs. or ... min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work.....None
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 9-BIRTHPLACE, (State or Country), Balt. Md

PARENTS.

10-NAME OF FATHER, Elijah Brown
 11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md
 12-MAIDEN NAME OF MOTHER, Louise Neil
 13-BIRTHPLACE OF MOTHER (State or Country), Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elijah Brown
 (Address) 1349 Carroll St

15-

Filed..... 191... HARRY O. ANDERSON, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 8, 1915
 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 22, 1915 to Aug 8, 1915, that I saw her alive on Aug 8, 1915, and that death occurred, on the date stated above, at 10.4 am. The CAUSE OF DEATH* was as follows:

Pneumonia (Bacterial)
 (Duration)..... yrs..... mos. 17 ds.

CONTRIBUTORY..... (Secondary).....

(Signed) Walter Brown M. D.
8/9/15, 191... (Address) Garnet Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mount Auburn Aug. 10, 1915

20-UNDERTAKER, ADDRESS

John Brown & Son 901 Hollis St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 10204 E. Lombard St.; yrs... 10 mos. ds.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH, Aug 9, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1915, to Aug 9 1915 that I saw her alive on Aug 9 1915 and that death occurred, on the date stated above, at 9 a. m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

CONTRIBUTORY *Measles*
(Secondary)
(Duration) yrs. mo. *6* d.
(Signed) *A. Palmisano* M. D.
Aug 9, 191*5* (Address) *316 S. E. 1st*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death	Yrs.	mos.	ds.	In the State	Yrs.	mos.	ds.
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Where was disease contracted,
if not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL

St. Vincent's Am

Aug 10 1914

20-UNDERTAKER

ADDRESS

4038 *Wolff*

8.30 G. M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE	
CERTIFICATE OF DEATH.	
PLACE OF DEATH CITY OF BALTIMORE (No. <i>University End Hosp</i> ST. <i>4</i> WARD)	REGISTERED No. C (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
FULL NAME <i>Charles Holliday</i> (Residence in Baltimore: No. <i>Elliot City</i> 1100 University Hospital ST. yrs. mos. <i>3</i> ds.)	
PERSONAL AND STATISTICAL PARTICULARS.	
3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>Colored</i>
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>Married</i>	16-DATE OF DEATH, <i>Aug 5</i> , 191 <i>5</i> (Month) (Day) (Year)
6-DATE OF BIRTH, <i>Unknown</i> , 1 (Month) (Day) (Year)	17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>autopsy</i> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <i>autopsy</i> and that said deceased came to <i>his</i> death on the day stated above.
7-AGE, <i>50</i> yrs. <i>about</i> mos. ds. If LESS than 1 day, ... hrs. or ... min.?	The CAUSE OF DEATH* was as follows: <i>Septicemia</i> <i>(Gunshot wound)</i> (Duration) yrs. mos. ds.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Laborer</i> (b) General nature of industry, business, or establishment in which employed (or employer). <i>General</i>	CONTRIBUTORY (Secondary) <i>Gunshot wound</i> (Duration) yrs. mos. ds.
9-BIRTHPLACE, (State or Country), <i>Unknown</i>	(Signed) <i>J. J. Jeffers</i> M. D. (Address) <i>413 N. Carroll</i>
10-NAME OF FATHER, <i>Unknown</i>	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
11-BIRTHPLACE OF FATHER (State or Country), <i>Unknown</i>	18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death, yrs. mos. ds. In the yrs. mos. ds.
12-MAIDEN NAME OF MOTHER, <i>Unknown</i>	Where was disease contracted, if not at place of death? <i>Howard Co. Elliot City</i>
13-BIRTHPLACE OF MOTHER (State or Country), <i>Unknown</i>	Former or usual residence <i>Howard Co. Elliot City</i>
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>University Hospital</i> (Address)	19-PLACE OF BURIAL OR REMOVAL, <i>Elliot City</i> 20-UNDERTAKER, <i>Samuel A. Hensley</i>
15- AUG 10 1915 Filed <i>HARRY O. ANDREWS,</i> 191. <i>Special Permit Clerk</i> Registrar.	DATE OF BURIAL, <i>Aug 11</i> , 191 <i>5</i> ADDRESS <i>576, Budd...</i>

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *2407 W. North ave.* ST.; *15* WARD)FULL NAME *Theodore Egbert Thomas Third*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *2407 W. North ave* St.; *life* yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word)

6-DATE OF BIRTH,

Aug 30
(Month)*29*
(Day)*1914*
(Year)

7-AGE,

0 yrs. *9* mos. *10* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), *City*10-NAME OF FATHER, *Theodore Egbert Thomas 2nd*11-BIRTHPLACE OF FATHER (State or Country) *Philadelphia Pa*12-MAIDEN NAME OF MOTHER *Lydia Somerville*13-BIRTHPLACE OF MOTHER (State or Country), *City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Theodore Egbert Thomas 2nd
(Informant)*2407 W. North ave*
(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 8*, *1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 3, *1915*, to *Aug 8*, *1915*,that I saw him alive on *Aug 8*, *1915*,and that death occurred, on the date stated above, at *7:30 P.M.*

The CAUSE OF DEATH* was as follows:

Acute Enteritis -(Duration).....*7* ds.CONTRIBUTORY (Secondary) *Alimentary intoxication*(Duration).....*4* ds.(Signed).....*J. Carroll Forehand*, M. D.*Aug 9*, *1915*. (Address).....*4 E. Preston St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery*DATE OF BURIAL, *8/11/15*20-UNDERTAKER *E. W. Weber & Son 2503 Edmondson ave*

ADDRESS

15-

AUG 10 1915

HARRY O. ANDREWS

Baltimore City

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.;

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15

Filed

191

HARRY O. ANDREWS

BALTIMORE REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-

I HEREBY CERTIFY, That I attended deceased from

18-

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87346

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 E Lombard ST.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1923 E Lombard St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

Feb. 16, 1835
(Month) (Day) (Year)

7-AGE,

80 yrs., 5 mos., 20 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Germany

PARENTS.

10-NAME OF FATHER,

Don't know

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George J. J. J.

(Address) 1923 E Lombard

15-

Filed

AUG 10 1915

191

HARRY O. ADAMS
Marital Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 8, 1915.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Feb. 14 1914, to Aug 8 1915,

that I saw her alive on Aug 6 1915,

and that death occurred, on the date stated above, at 8/15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
nephritis

(Duration) yrs. 19 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. 15 mos. ds.

(Signed) Geo. Heller M. D.

8-9, 1915 (Address) 1923 E Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer Cem

Aug. 16, 1915.

20-UNDERTAKER

ADDRESS

Wendell H. H. H.

375 Am St

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *3 N Duncan St.* ST.: *6* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Margaret Herbert (Margaret Herbert)*
(Residence in Baltimore: No. *3 N Duncan* St.: *Life* yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
6-DATE OF BIRTH, *January 11, 1880*
(Month) (Day) (Year)
7-AGE, *35* yrs., *6* mos., *28* ds. If LESS than 1 day,hrs. or....min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housekeeper*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Baltimore*

PARENTS.
10-NAME OF FATHER, *Frank Brown*
11-BIRTHPLACE OF FATHER (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER *Margaret Herbert*
13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles Herbert*
(Address) *3 N Duncan*

15-

Filed *AUG 10 1915* *HARRY O. ANDREWS,*
191- *CLAY*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 8, 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Aug 1, 1915*, to *Aug 8, 1915*, that I saw him alive on *Aug 7, 1915*, and that death occurred, on the date stated above, at *7:45* p. m.

The CAUSE OF DEATH* was as follows:

acute phthisis
(Duration) *2* yrs., *2* mos., *28* ds.

CONTRIBUTORY (Secondary).....

(Signed) *J. McLean* M. D.
79 1915 (Address) *1100 Brady*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer* DATE OF BURIAL, *Aug 11, 1915*

20-UNDERTAKER *Nedell Hippel* ADDRESS *37 N Duncan*

Valentine S Bawa

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *317 E Wolfe*)

2-FULL NAME *Sigmund Bolander*

(Residence in Baltimore: No. *317 E Wolfe*)

REGISTERED NO. C

ST. *2* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str. yrs. *3* mos. *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6-DATE OF BIRTH *April 14, 1915*
(Month) (Day) (Year)

7-AGE *3* yrs. *26* mos. *26* ds. or *1* day, *Mrs.* min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Polish*

10-NAME OF FATHER *Samuel Bolander*

11-BIRTHPLACE OF FATHER (State or country) *Warsaw Poland Russia*

12-MAIDEN NAME OF MOTHER *Rosie Shapiro*

13-BIRTHPLACE OF MOTHER (State or country) *London England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Chas. A. Brundick*

(Address) *88 Patterson Park*

15-AUG 10 1915 HARRY O. ANDREWS, MARIAL PERMIT CLERK

Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August 10, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 8, 1915*, to *Aug 10, 1915*, that I saw him alive on *Aug 10, 1915*, and that death occurred, on the date stated above, at *110 A* m. The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) yrs. mos. *3* ds

Contributory *Convulsions*
(SECONDARY)

(Duration) yrs. mos. *1* ds.

(Signed) *Alfred A. Brundick* M. D. (Address) *88 Patterson Park*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hebrew Friendship *8/9/15*

20-UNDERTAKER ADDRESS

Jack Lewis *1419 E. Naylor St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1134 N. Calhoun* ST. *16* WARD)

2-FULL NAME

Roland Harris(Residence in Baltimore: No. *1134 N. Calhoun* St.; yrs. *5* mos. *11* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Child*

6-DATE OF BIRTH,

Feb 28, 1915
(Month) (Day) (Year)

7-AGE,

5 yrs. *11* mos. *11* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Child*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Balto, Md

PARENTS.

10-NAME OF FATHER,

Samuel Harris

11-BIRTHPLACE OF FATHER (State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Sarah Chatman

13-BIRTHPLACE OF MOTHER (State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Samuel Harris*(Address) *1134 N. Calhoun St.*

AUG 10 1915

HARRY O. ANDERSON

Filed..... 1915

Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 9th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 6th, 1915* to *Aug 9th, 1915*, that I saw him alive on *Aug 8th, 1915*, and that death occurred, on the date stated above, at *8th* m.

The CAUSE OF DEATH* was as follows:

Enterocolitis(Duration)..... yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *Harry F. Brown* M. D. *Aug 9th, 1915* (Address) *1501 Presbiterian*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn Cemetery, 1915

20-UNDERTAKER

ADDRESS

Robt Gross 1405 Maryland St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Peabody Institute* ST. 11

79 REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *Peabody Institute* St.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH

Aug 31, 1885
(Month) (Day) (Year)

7-AGE

29 yrs. 11 mos. 8 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*House wife*

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *August Benella*(Address) *Peabody Institute*

15-

AUG 10 1915 HARRY O. ANDREWS, REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 8, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 18, 1915, to Aug 8, 1915,*that I saw her alive on *Aug 7, 1915,*and that death occurred, on the date stated above, at *5 a. m.*

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
(Duration)..... yrs. mos. ds.

CONTRIBUTORY..... (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *Harry O. Andrews* M. D.*Aug 7, 1915.* (Address) *602 E. Columbia*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Peabody Institute**Aug 10, 1915.*

20-UNDERTAKER

ADDRESS

*W. H. Anderson**North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155

087351

PLACE OF DEATH

CITY OF BALTIMORE (No. *1500 Patapsco* ST. *23* WARD)

FULL NAME

William G. B. Ingley

(Residence in Baltimore: No. *1500 Patapsco St*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *20* mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *married*

6-DATE OF BIRTH,

October 31st, 1864
(Month) (Day) (Year)

7-AGE,

50 yrs. *9* mos. *10* da.

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Book Keeper

9-BIRTHPLACE, (State or Country),

England

10-NAME OF FATHER,

William Ingley

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Aloina Ingley

(Address)

1500 Patapsco St

15-

Filed

AUG 10 1915

191

HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 9, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide & Insane

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) *Edy Grant* M. D. (Coroner)

Aug 10, 1915 (Address) *517 1/2 St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Glenwood Cem D.C.

Aug 11, 1915

20-UNDERTAKER

ADDRESS *502*

William Cook

& North on

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87332

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hoap* ST. *4* WARD)

REGISTERED NO. C.

2-FULL NAME

(Residence in Baltimore: No. *University Hospital* St. *4* yrs. *11* mon. *11* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

June 6, 18*75*
(Month) (Day) (Year)

7-AGE,

40 yrs. *7* mos. *3* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Glass cutter*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

W. Va.

10-NAME OF FATHER,

Ashford Brown

11-BIRTHPLACE OF FATHER (State or Country),

W. Va.

12-MAIDEN NAME OF MOTHER

Sarah Johnson

13-BIRTHPLACE OF MOTHER (State or Country),

W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Dr. C. P. Brown*(Address) *Frederick, N. Va.*

15-

Filed

AUG 10 1915

HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 9, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 29* 191*5*, to *Aug 9* 191*6*, that I saw him alive on *Aug 9* 191*5*, and that death occurred, on the date stated above, at *4:45 A.M.* The CAUSE OF DEATH* was as follows:*Cerebral Embolus*(Duration)yrs.mos. *4*ds.CONTRIBUTORY. *Pulmonary Edema*
(Secondary)(Duration)yrs.mos. *1*ds.(Signed) *W. H. Johnston, M. D.**Aug 10*, 191*5*. (Address) *University Hoap*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs.mos. *11* ds. in the State yrs.mos. *11* ds.Where was disease contracted, if not at place of death? *Unknown*Former or usual residence *Reedsville, W. Va.*

19-PLACE OF BURIAL OR REMOVAL,

Chapton N. Va.

DATE OF BURIAL,

Aug 10, 191*5*

20-UNDERTAKER

Joseph Cook

ADDRESS

1003 N. Balto

Every item of information should be carefully supplied. AGE must be stated EXACTLY. PHYSICIAN'S SIGNATURE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7* WARD)

2-FULL NAME *Walter Disney*

(Residence in Baltimore: No. *1531 Orleans Street* St.; yrs. *1* mos. *1* ds.)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *May 30th* 1915-
(Month) (Day) (Year)

7-AGE *2* yrs. *11* mos. *11* ds. or *1* day, *11* hrs., *11* min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Philadelphia Pa*

10-NAME OF FATHER *Walter Disney*

11-BIRTHPLACE OF FATHER (State or country) *Baltimore*

12-MAIDEN NAME OF MOTHER *Josephine Powers*

13-BIRTHPLACE OF MOTHER (State or country) *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. Roszel*

(Address) *Johns Hopkins Hospital*

15-

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 10th 1915-
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 24th* 1915- to *August 10th* 1915-
that I saw him alive on *August 10th* 1915-
and that death occurred, on the date stated above, at *2 4:00 A.M.*
The CAUSE OF DEATH* was as follows:

Acute intestinal indigestion

(Duration) yrs. mos. *17* ds.

Contributory (SECONDARY)

(Duration) yrs. mos. *17* ds.

(Signed), *Olivia S. Rothholz* M.D.

August 10th 1915- [Address] *Johns Hopkins Hospital*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *17* ds. State *2* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1531 Orleans St*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Calhoun Cem Aug 11

1915

20-UNDERTAKER

ADDRESS

Joe Brooks

1003 N. Baltimore St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE	
CERTIFICATE OF DEATH	
1-PLACE OF DEATH CITY OF BALTIMORE (No. <i>1905 Wilkens Ave</i>)	40 REGISTERED No. C (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME (Residence in Baltimore: No. <i>1905 Wilkens Ave</i>)	65 yrs. 11 mos. 2 ds.)
PERSONAL AND STATISTICAL PARTICULARS	
3-SEX <i>Female white</i>	4-COLOR OR RACE <i>White</i>
5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	<i>Widow</i>
6-DATE OF BIRTH <i>Sept. 6, 1849</i>	(Month) (Day) (Year)
7-AGE <i>65</i> yrs. <i>11</i> mos. <i>2</i> ds.	If LESS than 1 day, hrs. or min.?
8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)	
<i>Housework at home.</i>	
9-BIRTHPLACE (State or country)	
<i>Balto. Md.</i>	
10-NAME OF FATHER <i>Fredrick Wagner</i>	
11-BIRTHPLACE OF FATHER (State or country)	
<i>Germany</i>	
12-MAIDEN NAME OF MOTHER <i>Christina Price</i>	
13-BIRTHPLACE OF MOTHER (State or country)	
<i>Germany</i>	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Mrs. Maggie Hemmiller</i> (Address) <i>1905 Wilkens Ave</i>	
15. Filed <i>AUG 10 1915</i> 191 <i>HARRY O. ANDREWS,</i> REGISTRAR	
MEDICAL CERTIFICATE OF DEATH	
16-DATE OF DEATH <i>Aug 8, 1915</i> (Month) (Day) (Year)	
17. I HEREBY CERTIFY, That I attended deceased from <i>June 29, 1915</i> , to <i>Aug 7, 1915</i> , that I saw her alive on <i>Aug 7, 1915</i> , and that death occurred, on the date stated above, at <i>11 a</i> m. The CAUSE OF DEATH* was as follows: <i>Carcinoma Stomach</i> (Clinical Diagnosis) (Duration) <i>1</i> yrs. <i>6</i> mos. <i>6</i> ds. Contributory (SECONDARY) <i>Exhaustion</i> (Duration) <i>6</i> yrs. <i>6</i> mos. <i>6</i> ds. (Signed) <i>E. Miller Humming</i> M.D. <i>Aug 9, 1915</i> (Address) <i>2000 Holliston</i>	
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death <i>1</i> yrs. <i>6</i> mos. <i>6</i> ds. State <i>1</i> yrs. <i>6</i> mos. <i>6</i> ds. Where was disease contracted, If not at place of death? Former or usual residence	
19-PLACE OF BURIAL OR REMOVAL <i>Linden Pk. Cem.</i>	DATE OF BURIAL <i>Aug 11, 1915</i>
20-UNDERTAKER <i>Jack Cook</i>	ADDRESS <i>1003 N. Balto</i>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 565 Baker street,

ST. 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Gordon,

(Residence in Baltimore: No. 565 Baker street,

St.; yrs., 9 mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, November 7th, 1914. (Month) (Day) (Year)

7-AGE, 0 yrs., 9 mos., 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, James W. Gordon,

11-BIRTHPLACE OF FATHER, (State or Country), Virginia,

12-MAIDEN NAME OF MOTHER, Josephine Bunson,

13-BIRTHPLACE OF MOTHER, (State or Country), Virginia,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Gordon, mother,

(Address) 565 Baker street.

15- AUG 10 1915

Filed, 191, HARRY O. ANDREWS,

Marital Per Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 8th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Capillary bronchitis,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Granger, M. D. (Coroner.)

Aug. 9, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt. Zion Cemetery, Aug. 11, 1915

20-UNDERTAKER, ADDRESS

Geo. H. Holland, Robert H.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87356

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87356

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

547 Union

Maggie Jacob

547 Union (Greenwillow) Life

120

17

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Unknown, 1872

7 AGE

43 yrs. - mos. - ds. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housekeeper at home

9 BIRTHPLACE (State or country)

md Balto City

10 NAME OF FATHER

Michael Jacob

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Buttman

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Liedlich

(Address) 213 N. Lindwood Ave

15

HARRY O. ANDREWS

Filed AUG 10 1915 Serial Permit 0191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug. 8, 1915

17 I HEREBY CERTIFY, That I attended deceased from

Sep 22nd, 1914, to Aug 8, 1915

that I saw her alive on Aug 8, 1915

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Contributory (SECONDARY)

(Duration) 1 yrs. - mos. - ds.

Exhaustion

(Signed) Chas. H. Bulant, M. D.

Aug 10, 1915 (Address) 1100 W. Luf. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. - mos. - ds. In the State yrs. - mos. - ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

Aug 11, 1915

20 UNDERTAKER

Samuel Epton

ADDRESS

Penna Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087357

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

087357

PLACE OF DEATH

CITY OF BALTIMORE (No. 2029 Bank

2-FULL NAME

Mary Margaret Reintzell

(Residence in Baltimore: No. 2029 Bank

St.: 2

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

St.: yrs., 2 mos., 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 29, 1913
(Month) (Day) (Year)

7-AGE,

2 yrs., 11 mos., 11 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

Charles F. Reintzell

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Pauline Hoffert

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Margaret Arthur

(Address)

2029 Bank St.

15-

AUG 10 1915

Chas. M. Hildner

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 9, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental
Scalded by hot water

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) D. W. Jones M. D.

(Coroner.)

Aug 9, 1915 (Address) 3116 O'Donnell St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Carmel Cem

Aug 11 1915

20-UNDERTAKER

ADDRESS

John Henning & Co

2008 Orleans

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. 15 WARD

2-FULL NAME

(Residence in Baltimore: No.

St. 17 yrs. 7 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) single

6-DATE OF BIRTH Jan. 1 - 1914, 1 (Month) (Day) (Year)

7-AGE 1 yrs. 7 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Balto.

10-NAME OF FATHER

Poland D Shump

11-BIRTHPLACE OF FATHER (State or country)

Md.

12-MAIDEN NAME OF MOTHER

Josephine Pullerson

13-BIRTHPLACE OF MOTHER (State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug. 7, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY. That I attended deceased from

July 33, 1915, to, Aug 7, 1915.

that I saw her alive on Aug 8, 1915.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Atherosclerosis

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

Cardiac Failure

(Signed)

Aug 9, 1915. (Address) 1403 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spring Ridge Cemetery Aug 11, 1915

20-UNDERTAKER

ADDRESS

Katherine J. J. 1723 W. Lafayette Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87359

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87359

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Debrew Hospital*)ST. *2*

WARD)

REGISTERED NO. C

FULL NAME

Edward Dobryzowski

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1722 Aliceanna*)St. *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE

Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH,

March 2nd, 1905
(Month) (Day) (Year)

7-AGE,

10 yrs. 5 mos. 3 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*School Boy*9-BIRTHPLACE,
(State or Country).*Baltimore Md*

10-NAME OF FATHER,

*Martin Dobryzowski*11-BIRTHPLACE OF FATHER
(State or Country).*Germany*

12-MAIDEN NAME OF MOTHER

*Stanislawa Docha*13-BIRTHPLACE OF MOTHER
(State or Country).*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. F. Sadowski

(Address)

705 S. Ann St.

15-

Filed

AUG 10 1915

191

Chas. M. Sadowski

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 9th, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquiry*
(Inquest, au-topsy or inquiry.) find that said deceased came to *his* death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Petanus

(Duration) yrs. mos. ds.

CONTRIBUTOR (Accident) *Laceration of right*
(Secondary) *foot Aug 2nd 1915*

(Duration) yrs. mos. ds.

(Signed) *Edwin P. Russell* M. D.
(Coroner.)*Aug 12th 1915* (Address) *423 N. Broadway*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. 7 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death

*1722 Alice Anna St*Former or usual residence *1722 Alice Anna St*

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

Aug 12th 1915

20-UNDERTAKER

M. F. Sadowski

ADDRESS

705 S. Ann St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87360

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1807 Linden Ave* ST. *14* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1807 Linden Ave* St. *Lifton* yrs. *1* mos. *1* da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male
~~Female~~

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

July 8, 1850
(Month) (Day) (Year)

7-AGE,

65 yrs. 7 mos. 1 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 9, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 1914, to *Aug. 9 1915*,
that I saw him alive on *Aug 9 1915*,
and that death occurred, on the date stated above, at *3 P.m.*

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(Duration) *1* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

Nephritis
(Duration) *1* yrs. *1* mos. *1* ds.

(Signed)

Jose L. Smith
Aug 10, 1915 (Address) *1819 Lombard St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Har Sinai

DATE OF BURIAL,

8/11, 1915

20-UNDERTAKER

Karla Soudheim

ADDRESS

1819 Lombard St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87361 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. Lifetime yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

October 24, 1888

(Month)

(Day)

(Year)

7-AGE,

26 yrs. 9 mos. 16 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife
General

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER,

Thomas E. Pearce

11-BIRTHPLACE

OF FATHER
(State or Country),

Md.

12-MAIDEN NAME

OF MOTHER

Catherine Stabler

13-BIRTHPLACE

OF MOTHER
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Accord Mercy Hosp.

(Address)

Calvert St.

15-

Filed

101

C. M. S. J. J. J.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 10, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

July 27, 1915, to Aug 10, 1915,

that I saw her alive on Aug 10, 1915,

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Epithelioma
(Operation and Microscopic Examination
of section)
(Duration) about 3 mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) 1 yrs. mos. ds.

(Signed)

Edward P. Smith

M. D.

Aug 10, 1915 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 13 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 2505 Penna. Ave.

Former or usual residence

2505 Penna. Ave.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

David Ridge Ave. 8/12/15

20-UNDERTAKER

ADDRESS

Chas. J. Evans & Son 11810 North Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87363

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Henry St.

ST. 92 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME Ralph LeRoy Simpson

(Residence in Baltimore: No. 1421 Henry St.

St. 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

July 3, 1887

(Month)

(Day)

(Year)

7-AGE.

28 yrs. 1 mos. 5 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Printer

9-BIRTHPLACE.
(State or Country).

Phil. Pa.

10-NAME OF FATHER,

Thomas M. Simpson

11-BIRTHPLACE OF FATHER
(State or Country).

Phil. Pa.

12-MAIDEN NAME OF MOTHER

Martha E. Thompson

13-BIRTHPLACE OF MOTHER
(State or Country).

Cambridge Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Thomas M. Simpson

(Address)

1421 Henry St.

15-

Filed.

191.

W. H. McClair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 8th, 1915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 5th 1915, to Aug. 8th 1915,

that I saw him alive on Aug. 8th 1915,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY.....Anemia.....

(Secondary)

(Duration) yrs. 3 mos. ds.

(Signed) Philip S. Soule M. D.

Aug. 9th 1915. (Address) 1432 William St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Olivet

Aug. 11, 1915.

20-UNDERTAKER

ADDRESS

Edw. L. Fanning 460 B. Hwy

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *12 E. Hamburg St.* ST.; *73* WARD)2-FULL NAME *Miss Kate Hinkel*(Residence in Baltimore: No. *12 East Hamburg St.* St.; *57* yrs., *11* mos. *1* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)

6-DATE OF BIRTH,

Sept. 11, 1857.
(Month) (Day) (Year)

7-AGE,

57 yrs., 11 mos., 1 ds.

If LESS than 1 day.

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Store keeper
*By goods & notions*9-BIRTHPLACE,
(State or Country),*Balto. Md.*

10-NAME OF FATHER,

*William P. Hinkel.*11-BIRTHPLACE OF FATHER
(State or Country),*Germany.*

12-MAIDEN NAME OF MOTHER

*Annie M. Ulrich*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Hinkel (Bro.)*(Address) *1012 Patapsco St.*

15-

Filed *Aug 10 1915*

191

Edw. J. Fanning

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 10, 1915.
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *January 1915*, to *Aug 10 1915*, that I saw her alive on *Aug 8.* 1915, and that death occurred, on the date stated above, at *7 A m.*
The CAUSE OF DEATH* was as follows:

The CAUSE OF DEATH* was as follows:

Exhaustion(Duration).....yrs.....mos. *10* ds.CONTRIBUTORY
(Secondary)*Carcinoma breast*
(Duration) *1 1/2* yrs.....mos. *10* ds.(Signed) *G. J. Fanning* M. D.*Aug 10, 1915.* (Address) *301 East Enoch St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Ceder Hill. Aug. 12, 1915.

20-UNDERTAKER ADDRESS

Edw. J. Fanning 1460 Battery Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1518 A Bethel*ST. *4* WARD)

REGISTERED No. C

2-FULL NAME

Andreas G. Heber

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1518 A Bethel*St. *Lifetime* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

July 24, 1865
(Month) (Day) (Year)

7-AGE,

50 yrs. *17* mos. *17* da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer
parving gang

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Nicholas Heber

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Caroline Rides

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James H. Heber

(Address)

1518 A Bethel St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 10, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

*Aug 8, 1915, to Aug 10, 1915,*that I saw him alive on *Aug 10, 1915,*and that death occurred, on the date stated above, at *1:30 P. m.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration)..... yrs. mos. *1* da.

CONTRIBUTORY (Secondary)

Broncho-pneumonia(Duration)..... yrs. mos. *1* da.(Signed) *W. D. Andrews* M. D.*Aug 10, 1915* (Address) *1540 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Holy Redeemer Church**Aug 13, 1915*

20-UNDERTAKER

ADDRESS

Mrs. Mrs. John H. Penfel 8014 Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 11 1915

Filed

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HARRY O. ANDREWS

Special Permit Clerk

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 N Montford Ave ST.: 7 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1107 N. Montford Ave St.: 7 yrs. 6 mos. 18 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH.

Jan 24, 1915
(Month) (Day) (Year)

7-AGE.

6 yrs. 18 mos. 18 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country)

Baltimore City

10-NAME OF FATHER

Henry A. Buckner

11-BIRTHPLACE OF FATHER

(State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER

Elsie L. Gardner

13-BIRTHPLACE OF MOTHER

(State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. A. Buckner(Address) 1107 N Montford Ave

15-

AUG 11 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 11, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1915, to Aug 11 1915, that I saw him alive on Aug 10 1915, and that death occurred, on the date stated above, at 2 P. M. The CAUSE OF DEATH* was as follows:Acute Indigestion

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.
Convulsions
(Signed) W. S. Sage M. D.
8/11, 1915. (Address) 719 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Baltimore County

DATE OF BURIAL.

Aug. 13., 1915.

ADDRESS

222 N. Broadway

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87367

C87367

104

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87368		HEALTH DEPARTMENT—CITY OF BALTIMORE		C87368	
PLACE OF DEATH		CERTIFICATE OF DEATH		104	
CITY OF BALTIMORE (No. 2005 Oak St.)		REGISTERED No. C		12	
2-FULL NAME Robert Johnson		ST. 12		WARD	
(Residence in Baltimore: No. 2005 Oak St.)		St. 4		yrs. 4 mos. 18 ds.	
PERSONAL AND STATISTICAL PARTICULARS					
3-SEX Male	4-COLOR OR RACE Colored	5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single	16-DATE OF DEATH Aug - 10, 1915		
6-DATE OF BIRTH March 23, 1915			(Month) (Day) (Year)		
7-AGE 4 yrs. 4 mos. 18 ds.	If LESS than 1 day, hrs. or min.?		17. I HEREBY CERTIFY. That I attended deceased from Aug. 7 th , 1915, to Aug. 10, 1915.		
8-OCCUPATION None		that I saw him alive on Aug. 10, 1915, and that death occurred, on the date stated above, at 8:30 P. M.			
9-BIRTHPLACE Maryland (City)		The CAUSE OF DEATH* was as follows:			
10-NAME OF FATHER George Johnson		Intestinal tuberculosis and pneumonia			
11-BIRTHPLACE OF FATHER Virginia		Contributory (SECONDARY) (Duration) yrs. mos. ds.			
12-MAIDEN NAME OF MOTHER Catherine Ford		Robert H. Milledge M. D.			
13-BIRTHPLACE OF MOTHER Virginia		(Signed) Aug. 10, 1915 (Address) 2112 Maryland Ave			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) Catherine Johnson					
(Address) 2005 Oak St.					
15 AUG 11 1915					
HARRY O. ANDREWS, REGISTRAR					
19-PLACE OF BURIAL OR REMOVAL Laurel Cemetery					
20-UNDERTAKER John H. Trachin					
DATE OF BURIAL August 11, 1915					
ADDRESS 14210 Hill St.					

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87369

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

87369

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

104
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw h. & b. alive on and that death occurred, on the date stated above, at 5 P. m. The CAUSE OF DEATH* was as follows:

Acute Gastric-Intestinal Toxemia

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, of, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

15 AUG 11 1915

HARRY Q. ANDREWS,

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

AUG 11 1915

HARRY O. ANDREWS,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 9th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said
(Inquest, au-

..... and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Org. and Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Aug 9, 1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Landon Park Aug 11, 1915

20-UNDERTAKER

ADDRESS

H. Sander & Sons 1214 St

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87371

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87371

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1029 Bush* ST. *21* WARD)

2-FULL NAME *Raymond L. Greason*

(Residence in Baltimore: No. *1029 Bush* St.; yrs. *1* mos. *16* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Infant* (Write the word.)

6-DATE OF BIRTH, *June 25th 1915* (Month) (Day) (Year)

7-AGE, *1 16* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *None* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balto. Md*

10-NAME OF FATHER, *George Greason* 11-BIRTHPLACE OF FATHER, *Md.*

12-MAIDEN NAME OF MOTHER, *Agnes Fitzpatrick* 13-BIRTHPLACE OF MOTHER, *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Agnes Greason*

(Address) *1029 Bush St.*

AUG 11 1915

HARRY O. ANDREWS,

Filed, 1915

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 10th 1915* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Convulsions*

(Duration) yrs. mos. ds.

(Signed) *Sam'l Winkler* M. D. (Coroner.)

Aug 11th 1915 (Address) *2302 Madison St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Waver Hill Cem.* DATE OF BURIAL, *Aug 11th 1915*

20-UNDERTAKER, *Charles M. Hill* ADDRESS, *3189*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asy.* ST.; *14* WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary Lawrence

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. *1* mos. *4* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

July *6th*, *1915*.
(Month) (Day) (Year)

7-AGE,

yrs. *1* mos. *4* da.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Maryland

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*

(Address) *1421 Division St.*

15-

AUG 11 1915

Filed *1915* *Marital Permit Office* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August *10th*, *1915*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 6th* 1915, to *August 9* 1915, that I saw her alive on *August 9* 1915, and that death occurred, on the date stated above, at *500 a. m.*

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration) yrs. *1* mos. *4* da.

CONTRIBUTORY (Secondary)

(Duration) yrs. *1* mos. *4* da.

(Signed) *J. E. Poulson* M. D.

Aug. 10., 1915. (Address) *615 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *4* da. In the State yrs. *1* mos. *4* da.

Where was disease contracted, if not at place of death?

Former or usual residence *St. Vincent's Infant Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral *Aug. 11., 1915.*

20-UNDERTAKER

ADDRESS

M. F. Ahern & Sons 606 Lafayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Agatha W. Wums.(Residence in Baltimore: No. *St. Vincent's Inf. Asylum* St.; yrs., 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

July 3rd, 1915.
(Month) (Day) (Year)

7-AGE,

yrs. *1* mos. *7* ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE, (State or Country),

In England

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

AUG 11 1915

HARRY O. ANDREWS,

Filed 191. *HARRY O. ANDREWS, Registrar.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 10th, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 3rd, 1915*, to *Aug 10th, 1915*, that I saw her alive on *Aug 10th, 1915*, and that death occurred, on the date stated above, at *4:45 p.m.*

The CAUSE OF DEATH* was as follows:

Malnutrition and Malassimilation
(Duration) yrs. *1* mos. *7* ds.

CONTRIBUTORY (Secondary)

(Signed) *J. E. Sullivan* M. D.
Aug. 10, 1915. (Address) *615 Columbia Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *7* ds. In the State yrs. *1* mos. *7* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *St. Vincent's Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Cathedral *Aug. 11, 1915.*

20-UNDERTAKER

ADDRESS

M. Fahney & Sons 606 Lafayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087374

HEALTH DEPARTMENT—CITY OF BALTIMORE

087374

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. 19 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 4 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

April 5, 1915 (Month) (Day) (Year)

7 AGE

4 yrs. 5 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

Baltimore

10 NAME OF FATHER

Leo Hammersley

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Kate Beebling

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Kate Hammersley
(Address) 245 N. Gilman St.

15.

AUG 11 1915

HARRY O. ANDREWS,

Marial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 10, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from Aug 1st, 1915, to Aug 10, 1915.

that I saw her alive on Aug 10, 1915, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Summer Drowns

Contributory (SECONDARY)

Exhaustion (Duration) 2 yrs. 2 mos. ds.

(Signed)

Harry Goldstein M.D.
Aug. 10th, 1915 (Address) 2031 W. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery Aug 11, 1915

20 UNDERTAKER

ADDRESS

Joe Cook 1003 N. Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Howard A. Kelly Hospital* REGISTERED NO. C. *40*
 CITY OF BALTIMORE: (No. *1418 E. Fair Place* ST. *14* WARD)
 2-FULL NAME *Sue Sparks, nee Leod*
 (Residence in Baltimore: No. *Howard A. Kelly San. Home* St.; yrs. mos. *6* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
 6-DATE OF BIRTH, *Jan. 23* 18*64*.
 (Month) (Day) (Year)
 7-AGE, *51* yrs. *6* mos. *18* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

South Carolina
U. S. A.

PARENTS.

10-NAME OF FATHER, *Alexander Sparks*
 11-BIRTHPLACE OF FATHER (State or Country), *S. C.*
 12-MAIDEN NAME OF MOTHER *Carrie Dudley*
 13-BIRTHPLACE OF MOTHER (State or Country), *Bennettsville S. C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Kate E. Donaldson*
 (Address) *Bennettsville S. C.*

15-

Filed

AUG 11 1915

191

HARRY O. ANDREWS,

Marital Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 10* 191*5*.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *August 6* 191*5*, to *August 10* 191*5*, that I saw her alive on *August 10* 191*5*, and that death occurred, on the date stated above, at *11:55 P. M.*

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Dist. Marten
 (Duration) yrs. mos. *1* ds.

CONTRIBUTORY (Secondary)

Coronary Artery
(Nuxtomia) (Duration) yrs. mos. ds.
 (Signed) *William H. Hall* M. D.
Aug 11 191*5*. (Address) *1418 E. Fair Place*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. *6* ds. In the State yrs. mos. *6* ds.

Where was disease contracted, if not at place of death? *Sancti Carolus*

Former or usual residence *Bennettsville S. C.*

19-PLACE OF BURIAL OR REMOVAL,

Bennettsville Marlboro DATE OF BURIAL, *Aug 11* 191*5*.

20-UNDERTAKER

Chas. G. Black ADDRESS *1201 W. Mulberry*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *2658 Rayner Ave.* ST. *15* WARD)

FULL NAME *Abraham Gregory (Gregory)*

(Residence in Baltimore: No. *2658 Rayner Ave.* ST. *15* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *Colored* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *married* (Write the word)

6 DATE OF BIRTH *Aug*, *1855* (Month) (Day) (Year)

7 AGE *60* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Laborer* (b) General nature of industry, business, or establishment in which employed (or employer) *General*

9 BIRTHPLACE (State or country) *Va.*

10 NAME OF FATHER *William H. Gregory*

11 BIRTHPLACE OF FATHER (State or country) *Va.*

12 MAIDEN NAME OF MOTHER *Ann McCargo*

13 BIRTHPLACE OF MOTHER (State or country) *Va.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Frank Gregory*

(Address) *1031 Argy Ave.*

15 AUG 11 1915

HARRY O. ANDREWS,

Filed *1915* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Aug 9*, *10*, *1915* (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *June 10*, 1915, to *Aug 10*, 1915, that I saw him alive on *Aug 9*, 1915, and that death occurred, on the date stated above, at *3 1/2* m. The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

Contributory (SECONDARY) *Interstitial Nephritis* (Duration) yrs. *2* mos. ds.

(Signed) *Edw. W. C. Ye* M. D. 8/10, 1915 (Address) *1118 Dr. W. C. Ye*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Andrew's Church *Aug 11, 1915*

20 UNDERTAKER ADDRESS

Edward W. C. Ye *617 Winters Ave.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 28

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 Colu. Ave. St. 17. WARD)

2-FULL NAME

(Residence in Baltimore: No. 916 Columbia Ave. St. 17 yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married (Write the word.)

6-DATE OF BIRTH, Aug 9th, 1888

(Month)

(Day)

(Year)

7-AGE, 27

yrs. - mos. - da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balt. Md.

10-NAME OF FATHER, Jeremiah Ahern

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Nellie Fitzgibbons

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ahern

(Address) 3268 Gilman St.

15-

Filed

AUG 11 1915

191

BARRY O. ANDREWS

BART. PERMIT 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 9, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 1915, to Aug 9 1915

that I saw her alive on Aug 8 1915

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lung about 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac weakness

(Duration) yrs. mos. ds.

(Signed) A. D. Driscoll

Aug. 9, 1915 (Address) 2201 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Aug 12, 1915

20-UNDERTAKER, Jas. Wignam & Son

ADDRESS, 1009 S. Pica

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

87379

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1119 Ething St.

28
14
ST. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME William G. Leaves

(Residence in Baltimore: No. 1119 Ething St.

St. 10 yrs. 10 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Colored

5. SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6. DATE OF BIRTH

Dec.

1877

(Month)

(Day)

(Year)

7. AGE

38

yrs.

1 mos.

ds.

If LESS than
1 day, hrs.
or min.?

8. OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

Porter

9. BIRTHPLACE

(State or country)

Md.

10. NAME OF FATHER

William G. Leaves

11. BIRTHPLACE OF FATHER
(State or country)

Md.

12. MAIDEN NAME OF MOTHER

Agnes Baker

13. BIRTHPLACE OF MOTHER
(State or country)

Md.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ellen G. Leaves

(Address)

1119 Ething Street

15.

Filed

AUG 11 1915

191

HARRY O. ANDREWS,

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug

10

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 26

191

to

Aug 10

191

that I saw him alive on

Aug 17

191

and that death occurred, on the date stated above, at

9:30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory
(SECONDARY)

(Duration)

yrs.

3 mos.

ds.

(Signed),

(Duration)

yrs.

3 mos.

ds.

(Address) 1119 Ething St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Mt. Zion Cemetery

DATE OF BURIAL

Aug. 12, 1915

20. UNDERTAKER

George H. Holland

ADDRESS

317 Robert St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and RH cert No. 18.)

St.: 2 yrs. 2 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed 11 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on Aug 9 1915, and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 2 yrs. 2 mos. In the State 2 yrs. 1 mos. — ds.

Where was disease contracted, if not at place of death? Previous to admission to home
Former or usual residence St. Elizabeth's Home

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87381

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1622 N Bethel* ST. *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME

(Residence in Baltimore: No. *1622 Bethel St.* St. *59* yrs., *-* mos., *-* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH.

*Sept 11**1855*

(Month)

(Day)

(Year)

7-AGE.

59 yrs., *11* mos., *30* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Watchman

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country).*Germany*

10-NAME OF FATHER.

*Ludwig Hahn*11-BIRTHPLACE OF FATHER
(State or Country).*Germany*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country).*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Hahn

(Address)

1622 Bethel St.

15-

AUG 11 1915

DANNY O. ANDERSON,

108 N. 1st St. PERMITS CLERK.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 10, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 8 1915, to *Aug 10* 1915,that I saw him alive on *Aug 19* 1915,and that death occurred, on the date stated above, at *4 P. m.*

The CAUSE OF DEATH* was as follows:

Cor. Endocarditis
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)*A. Bronchitis*
(Duration).....yrs.....mos.....ds.(Signed) *Walter W. White* M. D.*Aug 11*, 1915 (Address) *1101 Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

M. J. Carmichael *Aug 11* 1915.

20-UNDERTAKER

ADDRESS

W. L. Turner *144 W. 1st St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

87382

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15 AUG 11 1915

HARRY O. ANDREWS,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY. That I attended deceased from

birth July 29, 1915, to Aug 9th 1915.

that I saw him alive on Aug 9th 1915.

and that death occurred, on the date stated above, at 8:20 P. M.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

Contributory (SECONDARY)

(Signed) G. M. A. T. Evans M. D.

Aug 9th 1915 (Address) 833 N. Fulton av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Not Olives Cemetery

Aug 11 1915

20 UNDERTAKER

ADDRESS

Harry H. Witzke

15316 Lombard St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

FILED

AUG 11 1915

HARRY O. ANDREWS,

Marital Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration)..... yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. da.

(Signed)..... M. D.

(Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1705 Gorsuch Ave.* ST.; *9* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1705 Gorsuch Ave.* St.; *60* yrs. *10* mos. *10* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

not known, *1* (Month) (Day) (Year)

7-AGE,

about 79 yrs. *10* mos. *10* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

not known

11-BIRTHPLACE OF FATHER (State or Country),

not known

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER (State or Country),

not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Mary A. Lorenz*
(Address) *1705 Gorsuch Ave.*

15-

AUG 11 1915 HARRY O. ANDREWS,
Filed. Serial Permit. Olex. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 10, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *August 1* 1915, to *August 10* 1915, that I saw her alive on *August 8* 1915, and that death occurred, on the date stated above, at *1:30* p.m.

The CAUSE OF DEATH* was as follows:

old age infirmities of
(Duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

(Signed) *James M. D.*
August 10 1915 (Address) *1705 Gorsuch Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Church

DATE OF BURIAL,

Aug. 12, 1915

20-UNDERTAKER

Harry Horck

ADDRESS

1201 E. Sagadahoc

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1401* *Ensor* ST.; *9* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1401* *Ensor*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *4* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Married*

6-DATE OF BIRTH,

April 13, *1872*
(Month) (Day) (Year)

7-AGE,

43 yrs., *3* mos., *28* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Bar tender*9-BIRTHPLACE,
(State or Country),*Pa.*

10-NAME OF FATHER,

*George P. Hintenach*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Theresa Heidenbren*13-BIRTHPLACE OF MOTHER
(State or Country),*Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Margaret Hintenach*(Address) *1401 Ensor St.*

15-

Filed

AUG 11 1915

HARRY O. ANDREWS,

191. *Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 11, *1915*
(Month) (Day) (Year)I HEREBY CERTIFY that I attended deceased from *July 8* *1915* to *Aug. 11* *1915*,
that I saw him alive on *Aug. 10* *1915*,
and that death occurred on the date stated above, at *2:00* p.m.

The CAUSE OF DEATH* was as follows:

*Acute Pulmonary Tuberculosis**Pulmonary Hemorrhage*
(Duration) *—* yrs., *—* mos., *—* ds.CONTRIBUTORY (Secondary) *Chronic M. D.*
Alleged 11.5, (Address) *1031 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs., *—* mos., *—* ds. In the State *—* yrs., *—* mos., *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer *Aug. 14*, *1915*

20-UNDERTAKER

ADDRESS

Henry Hoeck & Son *1301 E. Eager St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital) ST. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Maria E. Baser(Residence in Baltimore: No. 1375 North Gilman St. St. - yrs. - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE, <u>white</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>married</u>
-------------------------	----------------------------------	---

6-DATE OF BIRTH, unknown, 1854
(Month) (Day) (Year)7-AGE, 61 yrs. - mos. - ds. If LESS than 1 day, ... hrs. or ... min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), Maryland10-NAME OF FATHER, W. H. Baser11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER Maria E. Mason13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. A. O'Brien(Address) 1425-6 Carroll St.

15-AUG 11 1915 HARRY O. ANDREWS, Registrar.

Filed..... 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 9th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 6th, 1915, to Aug 9th, 1915, that I saw her alive on Aug 9th, 1915, and that death occurred, on the date stated above, at 6:40 P.M.The CAUSE OF DEATH* was as follows:
Myocarditis, Arteriosclerosis and Senility(Duration) unknown yrs. - mos. - ds.

CONTRIBUTORY (Secondary)

(Signed) M. D.
8/9, 1915. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, 1 yrs. 2 mos. 2 ds. In the 61 yrs. - mos. - ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1375 North Gilman St.19-PLACE OF BURIAL OR REMOVAL, St. Clare'sDATE OF BURIAL, Aug 11, 191520-UNDERTAKER, W. B. BrownADDRESS, North An

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH, Maryland General Hospital,
CITY OF BALTIMORE (No. Linden ave. & Madison st. ST. 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mollie Lambdin,
(Residence in Baltimore: No. (Non-resident) Md General Hospital St.; yrs. mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married, (Write the word.)

6-DATE OF BIRTH, December 4th, 1882.
(Month) (Day) (Year)

7-AGE, 32 yrs. 8 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife,
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, John H. Preller,

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Frauenholz,

13-BIRTHPLACE OF MOTHER (State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Rempel, brother in law.

(Address) 1102 Wilcox street.

15- AUG 11 1915 HARRY O. ANDERSON
Filed 191 Serial Permit 0101 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 9th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Septicchaemia- resulting from a self-induced abortion.
(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Signed) Frederick K. Humpal M. D. (Coroner.)
Aug. 9, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSFERS, OR RECENT RESIDENTS).

At place of death. yrs. mos. 7 ds. In the 3 yrs. 8 mos. 5 ds.

Where was disease contracted, if not at place of death?

Raspeburg, Baltimore Co., Md.

Former or usual residence. Raspeburg, Md.

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Aug 12, 1915.

20-UNDERTAKER ADDRESS

Chas. G. Black 1201 W. Mulberry St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 430 Orchard street,

ST. 17 WARD)

2-FULL NAME Samuel J. Briggs,

(Residence in Baltimore: No. 430 Orchard street,

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed, (Write the word.)

6-DATE OF BIRTH, Unknown, / (Month) (Day) (Year)

7-AGE, 60? yrs. ? mos. ? ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Expressman, (b) General nature of industry, business, or establishment in which employed (or employer), general hauling,

9-BIRTHPLACE. (State or Country), Virginia,

10-NAME OF FATHER, Unknown,

11-BIRTHPLACE OF FATHER (State or Country), Unknown,

12-MAIDEN NAME OF MOTHER, Unknown,

13-BIRTHPLACE OF MOTHER (State or Country), Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. Annie E. Briggs, daughter, (Informant)

(Address) 430 Orchard street,

15- Filed 1 1915 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 9th., 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably sclerosis of the Coronary arteries,

(Duration) yrs. mos. ds.

CONTRIBUTORY. (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Campbell M. D. (Coroner.)

Aug. 10, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

20-UNDERTAKER, ADDRESS.

John H. Bishop & Son

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Laura Allen*(Residence in Baltimore: No. *Univ. Hospital* St.: _____ yrs. _____ mos. *8* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Black*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Widow*

6-DATE OF BIRTH.

_____, *1865*
(Month) (Day) (Year)

7-AGE.

50

If LESS than 1 day.

____ hrs. or ____ min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *House Work*
(b) General nature of industry, business, or establishment in which employed (or employer). *at Home*9-BIRTHPLACE.
(State or Country).*Maryland*

10-NAME OF FATHER.

*Geo. Bond*11-BIRTHPLACE OF FATHER
(State or Country).*Maryland*

12-MAIDEN NAME OF MOTHER

*Hanna Bowyer*13-BIRTHPLACE OF MOTHER
(State or Country).*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *H. Allen*(Address) *611 E. 10th City*

15-

Filed _____, 191*5*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 9, 191*5*.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 1* 191*5*, to *Aug. 9* 191*5*, that I saw her alive on *Aug 9* 191*5*, and that death occurred, on the date stated above, at *1 P. m.*

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(Duration) *unknown* yrs. _____ mos. _____ da.CONTRIBUTORY
(Secondary)(Signed) *H. Allen* M. D.
8/10, 191*5*. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death _____ yrs. _____ mos. *8* da. In the *50* yrs. _____ mos. _____ da.Where was disease contracted, if not at place of death? *unknown*Former or usual residence *Dayton Howard Co. Ind.*

19-PLACE OF BURIAL OR REMOVAL

Brown's Chapel Cem.

DATE OF BURIAL.

Aug. 12, 191*5*

20-UNDERTAKER

Easton Sons

ADDRESS

Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital* REGISTERED NO. C
 CITY OF BALTIMORE: (No. *4* ST.; *4* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME *Beatrice Jackson*
 (Residence in Baltimore: No. *none* (*Elliott City Md*) St.; *4* yrs., *4* mos., *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *negro* 5-SINGLE, *Single* MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
 6-DATE OF BIRTH, *1911* (Month) (Day) (Year)
 7-AGE, *4* yrs., *4* mos., *4* ds. If LESS than 1 day, ...hrs. or...min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *none*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *ind.*

10-NAME OF FATHER, *Tom Jackson*
 11-BIRTHPLACE OF FATHER (State or Country), *ind.*
 12-MAIDEN NAME OF MOTHER, *Mary Johnson*
 13-BIRTHPLACE OF MOTHER (State or Country), *ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Tom Jackson*
 (Address) *Folly Waters Howard*

15-
 Filed..... 191*5* *Chas M. Sinclair*
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 11*, 191*5*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *August 7*, 191*5*, to *August 11*, 191*5*, that I saw him alive on *August 10*, 191*5*, and that death occurred, on the date stated above, at *12:40 p.m.*

The CAUSE OF DEATH* was as follows:

General Sepsis

(Duration)..... yrs. mos. ds.
 CONTRIBUTORY.....
 (Secondary)

(Duration)..... yrs. mos. ds.
 (Signed) *Mary M. Steen* M. D.
Aug 11, 191*5*. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the *4* yrs. mos. ds. State *4* yrs. mos. ds.

Where was disease contracted, if not at place of death? *the person*

Former or usual residence *Elliott City - ind.*

19-PLACE OF BURIAL OR REMOVAL, *School House Woodlawn* DATE OF BURIAL, *Aug. 13, 1915*

20-UNDERTAKER, *Easton Sons* ADDRESS, *Elliott City*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *538 N. Lakewood ave* ST.; *6* WARD)

2-FULL NAME

(Residence in Baltimore: No. *538 N. Lakewood ave* St.; *42* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

June 2, 1852
(Month) (Day) (Year)

7-AGE,

63 yrs. *2* mos. *2* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *At home*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Washington D.C.

10-NAME OF FATHER,

John Cook

11-BIRTHPLACE OF FATHER (State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Harriet Biggs

13-BIRTHPLACE OF MOTHER (State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John H. Clark*(Address) *419 N. Milton ave*

15-

Filed *Aug 11 1915*

191

Registrar. *Ch. Mueller*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 9, 1915
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *June 1910*, to *Aug 9, 1915*, that I saw her alive on *Aug 19, 1915*, and that death occurred, on the date stated above, at *2:15 P.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Fibroid)
(Duration) *6* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Helmut J. Robertson, D.M.D.*
Aug 10, 1915 (Address) *2129 E. Bait St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oaklawn Aug 12, 1915

20-UNDERTAKER

ADDRESS

Jirkler & Jirkler E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87392

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

37

87392

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Elizabeth Home* ST.

REGISTERED No. C

WARD)

2-FULL NAME

John Winston Hayward
St Paul St

(If death occurred in a hospital or institution, give its NAME instead of street and number and SN out No. 18.)

(Residence in Baltimore: No.

St.; yrs. *9* mos. *19* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

colored

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

Oct

23, 1914

(Month)

(Day)

(Year)

7-AGE

9

mos.

19

ds.

or 1 day, hrs., min.?

If LESS than

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Somerset Co. Md

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Reverend M. Childred
St Elizabeth Home

15-

Filed

191

Chas M. Linder
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug

11

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 20*, 1915, to, *Aug 11*, 1915, that I saw him alive on *Aug 10*, 1915, and that death occurred, on the date stated above, at *a* m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration)

yrs

9

mos.

19 ds.

Contributory (SECONDARY)

Tuberculosis

(Duration)

yrs

6

mos.

6 ds.

(Signed)

E. B. Brudenwald

M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs

mos

22

In the

State

yrs

mos

ds.

Where was disease contracted, if not at place of death?

at birth

Former or usual residence

unknown

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

COLLEGE OF P. & S.

AUG 11 1915

College of P. & S.

ADDRESS

Per, Wm E. WOODALL.

FOR ANATOMICAL PURPOSES

10- Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital*)

2-FULL NAME

Jim Szlachowski (Dabkowski)

(Residence in Baltimore: No. *1524 Thayer Street*)

REGISTERED NO. C. *104*

ST. *2* WARD

(If death occurred in hospital or institution, give its NAME instead of street and number and block No. 18.)

St. *1* yrs. *3* mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

May 7th

1914

7-AGE

1 yrs. *3* mos. *3* ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Baltimore

10-NAME OF FATHER

Joseph Szlachowski

11-BIRTHPLACE OF FATHER
(State or country)

Poland

12-MAIDEN NAME OF MOTHER

Katie Hugesko

13-BIRTHPLACE OF MOTHER
(State or country)

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Roszel
Johns Hopkins Hospital*

15-

FILE

191

Blumclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 10th

1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *August 10th*, 1915, to *August 10th*, 1915,

that I saw him alive on *August 10th*, 1915,

and that death occurred, on the date stated above, at *6:30 P.M.*

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(Duration) *1* yrs. *3* mos. *3* ds.

Contributory
(SECONDARY)

(Duration) *1* yrs. *3* mos. *3* ds.

(Signed)

G. A. Bortone

M. D.

Aug. 11th

1915

(Address)

Johns Hopkins Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *1* yrs. *3* mos. *3* ds. in the State *1* yrs. *3* mos. *3* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

1524 Thayer Street

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary

DATE OF BURIAL

Aug 12 1915

20-UNDERTAKER

Jacob Szlachowski

ADDRESS

428 S. Bond St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1505-E Monument*)

ST.:

WARD)

REGISTERED No. C.

2-FULL NAME

Evelyn R Morris

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1505-E Monument*)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Child

6-DATE OF BIRTH,

Oct 9th, 1914
(Month) (Day) (Year)

7-AGE,

10 mos. 1 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9-BIRTHPLACE, (State or Country).

MA

10-NAME OF FATHER,

Samuel Morris

11-BIRTHPLACE OF FATHER (State or Country).

MA

12-MAIDEN NAME OF MOTHER

Hellen Thompson

13-BIRTHPLACE OF MOTHER (State or Country).

MA

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Hellen Morris
1505-E Monument

15-

Filed

11 1915

19-

Chas. M. Sicular

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 10th, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, an-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cholera infantum

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Signed: *George F. Russell* M. D.

(Coroner)

Aug 11, 1915 (Address *423 N. Broadway*)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDE, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Ext. Green Cem

Aug 11, 1915

20-UNDERTAKER

ADDRESS

Harry A. Voderberg

1725 Eastern St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY...
(Secondary)

(Signed) S. J. ... M. D.

8-10-1915 (Address) 116 N. Highland ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 116 N. Highland ave.

Former or usual residence 116 N. Highland ave.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *18* WARD)2-FULL NAME *Olivia DuRand*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1033 Sarah Ann St.* St. *30* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*negro*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

Unknown, 1870
(Month) (Day) (Year)

7-AGE,

45 yrs. mos. ds.If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House Wife

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Provy Wilson

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Helen Ray*(Address) *1221 Jefferson St*

15-

Filed *AUG 12 1915*

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 18, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *August 2* 1915, to *August 10* 1915, that I saw her alive on *August 10* 1915, and that death occurred, on the date stated above, at *1:30* p.m.

The CAUSE OF DEATH*, was as follows:

Interstitial Nephritis and Intestinal Perforation (Cause unknown)(Duration) *Unknown* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Surgical shock(Duration) *1* yrs. mos. ds.(Signed) *E. J. ...**8-10-15*, 1915. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *8* yrs. *45* mos. *1* ds. State *MD* yrs. mos. ds.Where was disease contracted, if not at place of death? *Unknown*Former or usual residence *1033 Sarah Ann St*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mount Auburn Cemetery *Aug 18*, 1915.

20-UNDERTAKER

ADDRESS

Alfred J. ... *1142 S. ...*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 Arsguth St. ST. 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Wilson(Residence in Baltimore: No. 822 Arsguth St. St.; 56 yrs., 5 mos., 27 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH,

Feb. 15, 1859

(Month)

(Day)

(Year)

7-AGE,

56 yrs., 5 mos., 27 da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

at home
House Wife

9-BIRTHPLACE, (State or Country),

Balto Md.

10-NAME OF FATHER,

Wm. Harris

11-BIRTHPLACE OF FATHER (State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Eleanor Deal

13-BIRTHPLACE OF MOTHER (State or Country),

Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ada Smith(Address) 822 Arsguth St.

15-

AUG 12 1915

HARRY O. ANDREWS,

Filed 1915 Marial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 11, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 14 1915, to Aug 11 1915, that I saw her alive on Aug 9 1915, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis(Duration) 2 yrs., — mos., — da.

CONTRIBUTORY (Secondary)

Apoplexy(Duration) — yrs., 3 mos., — da.(Signed) A. B. Leacock M. D.Aug. 12, 1915. (Address) 1841 Penna. ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — da. In the State — yrs., — mos., — da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Balto Md.

DATE OF BURIAL,

Aug 14, 1915

20-UNDERTAKER

Wm. Coon

ADDRESS

1841 Penna. ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Wolfe 2236

C87400

CERTIFICATE OF DEATH.

104

C87400

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH 2035 Ahern REGISTERED NO. C 104
 CITY OF BALTIMORE: (No. 2035 ST.; 8 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 FULL NAME Sophia Slowikowska
 (Residence in Baltimore: No. 2035 Ahern St.; yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX Female 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)
 6-DATE OF BIRTH. Unknown
 (Month) (Day) (Year)
 7-AGE, 15 yrs. 15 mos. ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, John Slowikowski
 11-BIRTHPLACE OF FATHER (State or Country), Russia Poland
 12-MAIDEN NAME OF MOTHER Antonia Nowicka
 13-BIRTHPLACE OF MOTHER (State or Country), Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) John Slowikowski
 (Address) 2035 Ahern St.

15-
 AUG 12 1915 HARRY O. ANDREWS,
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 10, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 8 1915, to Aug 10 1915, that I saw h 5 alive on Aug 10 1915, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Infantile Convulsions
(Enteritis from eating peaches)

CONTRIBUTORY (Secondary) Indigestion
 (Duration) ... yrs. ... mos. ... ds. 3

(Signed) Will. J. Ryan M. D.
Aug 11, 1915 (Address) 2001 W. Howard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
 At place of death ... yrs. ... mos. ... ds. In the ... State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?
 Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus DATE OF BURIAL, Aug. 12, 1915

20-UNDERTAKER M. J. Sadowski ADDRESS 405 S. Ann

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87401

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1573 Carmell St. 9 WARD)

2-FULL NAME

Angeline Ritmiller

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 6 month St. yrs. mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE white 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH January 17 1915
(Month) (Day) (Year)

7-AGE 6 months 25 If LESS than 1 day, hrs., or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) 1573 Carmell St Baltimore

10-NAME OF FATHER Joseph Ritmiller

11-BIRTHPLACE OF FATHER (State or country) Baltimore

12-MAIDEN NAME OF MOTHER Helie Bowen

13-BIRTHPLACE OF MOTHER (State or country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Joseph Ritmiller

(Address) 1573 Carmell St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH August 11 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 2, 1915, to August 11, 1915, that I saw her alive on August 11, 1915, and that death occurred, on the date stated above, at 10:45 pm. The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. 4 ds.
Contributory (SECONDARY) Exhaustion

(Signed) Thos. W. Withers M. D.
August 12, 1915 [Address] 1618 Forest Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St Peter's Cem. DATE OF BURIAL Aug 13, 1915

20-UNDERTAKER A. Tink & Son ADDRESS 915 N. Gay St

AUG 12 1915

HARRY O. ANDREWS,
Burial Permit Clerk.

Filed 1915

REGISTRAR

C87402

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87402

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407-E-Chase ST.; 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Cass. Owen(Residence in Baltimore: No. 407-E-Chase St.; Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male4-COLOR OR RACE. White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH. October 24, 1852

(Month)

(Day)

(Year)

7-AGE. 62 yrs. 9 mos. 17 ds.

If LESS than 1 day,hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Clerk(b) General nature of industry, business, or establishment in which employed (or employer). P.R.R.9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, Geo. F. Owen11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER, Margaret R. Aler13-BIRTHPLACE OF MOTHER (State or Country), Balto. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. F. Owen(Address) 2510 N. Calvert St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 11, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17, 1914 to Aug 11, 1915, that I saw him alive on Aug 11, 1915, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia of Right Side
(Chronic Degeneration)(Duration) 2 yrs. mos. ds.CONTRIBUTORY (Secondary) Heart Stroke(Duration) 1 yrs. mos. ds.(Signed) John A. Cogan, M. D.
(Address) 101 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL, Aug 13, 1915Burial Ridge Cemetery

20-UNDERTAKER

Stewart Mowen Co

ADDRESS

108 N. North

15-

Filed, AUG 12 1915

HARRY O. ANDREW

Burial Parlor, 613 N. Calvert St.

Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87403

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

C87403

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2031 Madison Av ST. 13 WARD)

2-FULL NAME

Samuel De Wolff

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2031 Madison Av St.: - yrs. - mos. - da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widowed
(Write the word.)

6-DATE OF BIRTH, December 3, 1846
(Month) (Day) (Year)

7-AGE. 68 yrs. 9 mos. 8 da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Jewelry
(b) General nature of industry, business, or establishment in which employed (or employer). Business

9-BIRTHPLACE, (State or Country). Maryland

10-NAME OF FATHER. Benj De Wolff

11-BIRTHPLACE OF FATHER (State or Country). Holland

12-MAIDEN NAME OF MOTHER. Sarah Benjamin

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Jacob De Wolff

(Address). 2031 Madison Av.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 10, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1, 1915, to Aug 10, 1915, that I saw him alive on August 10, 1915, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:
Pulmonary Phthisis

(Duration)..... yrs. 6 mos. 11 da.

CONTRIBUTORY..... Exhaustion
(Secondary)

(Duration)..... yrs. mos. 15 da.

(Signed) Julius Friedman M. D.

August 12, 1915 (Address) 1913 1/2 Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. da. In the State..... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Culter N. Y. DATE OF BURIAL, Aug. 15, 1915

20-UNDERTAKER Stewart Mowen ADDRESS 18 W. North St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15- HARRY O. ANDREWS Aug 12, 1915 1915 Serial Permit 610

Registrar

C87404 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1722 William St.* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1722 William St.* St.; yrs., *4* mos. *16* da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) *Single*

6-DATE OF BIRTH.

Mar 24, 1915
(Month) (Day) (Year)

7-AGE.

4 yrs., *16* mos., *16* da.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country).*MD - Balt City*

10-NAME OF FATHER.

*Wm. J. Conway*11-BIRTHPLACE OF FATHER
(State or Country).*MD.*

12-MAIDEN NAME OF MOTHER

*Gerardine Kels*13-BIRTHPLACE OF MOTHER
(State or Country).*Scotland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Wm. J. Conway
1722 William St.

15-

AUG 12 1915

HARRY O. ANDREWS,

Filed *Aug 12 1915* 191.. *Barial Permis Clerk* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 10, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 1* 1915, to *Aug 10* 1915, that I saw him live on *Aug 10* 1915, and that death occurred, on the date stated above, at *2 P. m.*

The CAUSE OF DEATH* was as follows:

*Exhaustion*CONTRIBUTORY
(Secondary)(Signed) *R. P. Campbell* M. D.
Aug 11, 1915 (Address) *1644 Howard St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Calvary**Aug 12, 1915*

20-UNDERTAKER

ADDRESS

*Wm. J. Conway**1722 William St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87405

CERTIFICATE OF DEATH

C87405

1. PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *813 Scott St*)

ST. *21*, WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME *James M. Collum*

(Residence in Baltimore: No. *813 Scott St*)

St. *21* yrs. *4* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. ~~SINGLE~~ MARRIED *Married*
OR DIVORCED
(Write the word)

6. DATE OF BIRTH *June 19th, 1860*
(Month) (Day) (Year)

7. AGE *55* yrs. *121* mos. *21* ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

*Teamster
Coffee Wagon*

9. BIRTHPLACE (State or country)

Ireland

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER (State or country)

Ireland

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER (State or country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mrs Louise M. Collum
813 Scott St*

(Address)

15.

Filed

1915

Aug 11/5 Charles M. Budde

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 10, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from *June 10, 1915* to *Aug 10, 1915*.

that I saw him alive on *Aug 9th, 1915*

and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

Contributory (SECONDARY)

Exhaustion

(Signed)

Robert L. Slack, M.D.

Aug 11, 1915 (Address) *637 Columbia*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Loydson Park

DATE OF BURIAL

Aug 13th, 1915

20. UNDERTAKER

William J. F. 1725 N. Fayette

ADDRESS

1725 N. Fayette

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and Rm out No. 18.)

St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.,

yrs. 1 mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

16-

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

7- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal indigestion

(Duration) yrs. mos. 7 ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. 2 ds.

(Signed),

Aug. 12th, 1915 [Address] Johns Hopkins Hospital

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence 1547 Arguilla Street

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *222* *For Register* ST.; *222* *For Register* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *222* *For Register* St.; *222* *For Register* yrs., *18* mos. *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE, *Col.*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *July 24, 1915*

(Month)

(Day)

(Year)

7-AGE, *18*yrs. *18* mos. *18* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country), *Baltimore Md.*10-NAME OF FATHER, *James E. Griffin*11-BIRTHPLACE OF FATHER
(State or Country), *Baltimore Md.*12-MAIDEN NAME OF MOTHER *Ella Hatcher*13-BIRTHPLACE OF MOTHER
(State or Country), *Pocomoke City Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Griffin*(Address) *222 For Register St.*

15-

File

AUG 12 1915 *Baltimore*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 11, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 5, 1915*, to *Aug 11, 1915*, that I saw her alive on *Aug 11, 1915*, and that death occurred, on the date stated above, at *6:30 p.m.*

The CAUSE OF DEATH* was as follows:

*Abscess of left Shoulder
Joint - Probable Tubercular*
(Duration) *9* yrs. *9* mos. *9* ds.CONTRIBUTORY
(Secondary)(Duration) *9* yrs. *9* mos. *9* ds.(Signed) *Geo. L. Williams* M. D.*Aug 11, 1915* (Address) *6 N. Brown*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *9* yrs. *9* mos. *9* ds. In the State *9* yrs. *9* mos. *9* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Leavelle City

20-UNDERTAKER

Spadore White

ADDRESS

1702 20th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 432 N. Remwood ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah A. Way(Residence in Baltimore: No. 432 N. Remwood Ave St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

April 24, 1847
(Month) (Day) (Year)7-AGE, 7121 yrs., 3 mos., 17 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Way(Address) 432 N. Remwood Ave15 AUG 12 1915

Filed..... 191

191

Chas M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 10, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 10 1915, to Aug 10 1915, that I saw he alive on Aug 10 1915, and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Vail Glands
(Duration) 6 yrs., 6 mos., ds.CONTRIBUTORY
(Secondary)E.C. Owings(Signed) E.C. Owings M. D.
Aug 4, 1915 (Address) 1703 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Mount Carmel Church Aug 13, 1915

20-UNDERTAKER

ADDRESS

H. Sander Bros 1703 Linden Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 E' Chase

2-FULL NAME *Margareth Gable*

(Residence in Baltimore: No. 533 Rossiter ave

ST.; 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH

Aug

(Month)

(Day)

1850 (Year)

7-AGE,

65

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Nurse

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

George Ortel

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Katherine Miller

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. D. Ortel

(Address)

533 Rossiter Ave

15-

Filed

*16 + 2, 1915**W. S. Snelair*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 11, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Dec 28, 1914, to Aug 11, 1915*that I saw her alive on *Aug 11, 1915*and that death occurred, on the date stated above, at *7:30 p*

The CAUSE OF DEATH* was as follows:

Nephritis and Asthma

(Duration).....yrs.....7 mos. 14 ds

CONTRIBUTORY *Asthma and Heart*(Secondary) *Failure*

(Duration).....yrs.....7 mos. 7 ds

(Signed) *Adolph G. Richter**Aug 11, 1915* (Address) *2201-3*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....21 ds. In the State.....yrs.....ds.

Where was disease contracted if not at place of death? *533 Rossiter ave*Former or usual residence *533 Rossiter ave*

19-PLACE OF BURIAL OR REMOVAL.

Wood Lawn Cem

DATE OF BURIAL,

Aug 15, 1915

20-UNDERTAKER

H. Sander Sons

ADDRESS

1210 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

87410

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 7)

2-FULL NAME

(Residence in Baltimore: No. 7)

REGISTERED NO. C. 764

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

Feb.

8, 1914

7-AGE

1 yrs. 6 mos. 4 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Curtis Bay - Md. (following)

10-NAME OF FATHER

Alexander Waller

11-BIRTHPLACE OF FATHER
(State or country)

Buffalo N. Y.

12-MAIDEN NAME OF MOTHER

Bernice Ryzanowska

13-BIRTHPLACE OF MOTHER
(State or country)

Buffalo N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

16-

1915

Chas M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

August 12th

1915

17- I HEREBY CERTIFY, That I attended deceased from

August 11th, 1915, to, August 12th, 1915,

that I saw her alive on August 12th, 1915,

and that death occurred, on the date stated above, at 2:52 p.m.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

Mastoiditis =

Contributory (SECONDARY) Mastoiditis

(Signed) R. D. McClure

Aug. 12th, 1915. [Address] Johns Hopkins Hosp.

* State the DISEASE CAUSING DEATH or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 111 Cherry Street Curtis Bay

19-PLACE OF BURIAL OR REMOVAL

Cedar Hill Cemetery

20-UNDERTAKER

R. D. M. Flynn

1422 Light St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. **3 E Lee**)

ST. **27** WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME **Samuel Palmer**

(Residence in Baltimore: No.

119 W Hill St

St. **35** rs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) **Widowed**

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

45

yr. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Driver

(b) General nature of industry, business, or establishment in which employed (or employer).

Wagon

9-BIRTHPLACE,

(State or Country),

Va

10-NAME OF FATHER,

Henry Palmer

11-BIRTHPLACE OF FATHER

(State or Country),

Va

12-MAIDEN NAME OF MOTHER

Laura Chandler

13-BIRTHPLACE OF MOTHER

(State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Andrew Palmer**

(Address) **603 Archer St**

15-

AUG 12 1915

191

Chas. M. Sinclair

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug

10

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an **Inquiry** (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

Inquiry find that said deceased came to **His** death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

Sudden

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. J. Scott* M. D.

(Coroner.)

Aug 11, 1915 (Address) **517 Scott St**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

John H. Proctor **142 W Hill**

C87412

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87412

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Nursery & Childs*)

REGISTERED NO. C

2-FULL NAME

Harry Marshall Landin

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *Nursery & Childs*)*Franklin & Schneider*yrs. *85* mos. *21* ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

Jan 31

(Month)

(Day)

(Year)

7-AGE,

*6**21*

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Balti City

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Mary Schneider

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Nursery & Childs

(Address)

Franklin & Schneider

15-

Filed

*AUG 13 1915**Chas M. Leland*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 11

(Month)

11

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from, *Aug. 11 1915*, to *Aug 11 1915*, that I saw him alive on *Aug 11 1915*, and that death occurred, on the date stated above, at *8:40 a.m.*

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) *Edgar B. DeMerveld* M. D.*Aug. 11, 1915* (Address) *1616 Linden Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *6* mos. *21* ds. In the State *X* yrs. *6* mos. *21* ds.

Where was disease contracted, if not at place of death?

Nursery & Childs

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*London Park Cemetery**Aug. 13, 1915*

20-UNDERTAKER

George J. Smith

ADDRESS

Payette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 William ST.; 14 WARD)

FULL NAME

Residence in Baltimore: No. 1304 William St.; 5 yrs., 5 mos., 28 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, February 14, 1915
(Month) (Day) (Year)7-AGE, 5 yrs., 28 mos., 28 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Baltimore Md.10-NAME OF FATHER, Charles H. Johnson11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.12-MAIDEN NAME OF MOTHER Minnie Selters13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H. Johnson(Address) 1304 William St.15-AUG 13 1915 HARRY O. ANDREWS,
Filed 191 Baltimore Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 11th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 15 191 5, to Aug 11 191 5, that I saw h. 17 alive on Aug 10 191 5 and that death occurred, on the date stated above, at 10:50 A m.

The CAUSE OF DEATH* was as follows:

Enteritis Colitis
(Duration) 0 yrs., 0 mos., 30 ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. Sherman M. D.
Aug 11, 1915 (Address) 3100 Haystack

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill DATE OF BURIAL, Aug 13, 191520-UNDERTAKER E. B. Harle ADDRESS 115 E. West St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087414

HEALTH DEPARTMENT—CITY OF BALTIMORE

61

087414

PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

1410 Cooke

2-FULL NAME

Josephine Brown

ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1410 Cooke

St.: 1 yrs. 5 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6-DATE OF BIRTH *March 10th, 1914*
(Month) (Day) (Year)

7-AGE *1* yrs. *5* mos. *2* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION *None*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE *Baltimore Md*
(State or country)

10-NAME OF FATHER *Alexander Brown*

11-BIRTHPLACE OF FATHER *Baltimore Md*
(State or country)

12-MAIDEN NAME OF MOTHER *Cecelia Smolksi*

13-BIRTHPLACE OF MOTHER *Baltimore Md*
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Alexander Brown*

(Address) *1410 Cooke St*

15. *AUG 13 1915.* HARRY O. ANDREWS,
Filed, 1915, *Marital Permit Clerk*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August 12, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *August 8*, 1915, to *August 12* 1915, that I saw her alive on *August 12*, 1915, and that death occurred, on the date stated above, at *2:30 P. M.* The CAUSE OF DEATH* was as follows:

Epidemic Cerebrospinal meningitis
(Duration) *Don't know* yrs. mos. ds.

Contributory (SECONDARY) *None*
(Duration) yrs. mos. ds.

(Signed) *Walter Jones* M. D.
Aug 12, 1915 (Address) *4237 Fort St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Holy Cross (AAC)* DATE OF BURIAL *Aug 13, 1915*

20-UNDERTAKER *E. B. Nicks* ADDRESS *115 E. North St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87415

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87415

CERTIFICATE OF DEATH.

155

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Franklin Square West 15* WARD)

2-FULL NAME

Ella C. Myers

(Residence in Baltimore: No. *2516 Ashton*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Aug. 14th 1887
(Month) (Day) (Year)

7-AGE,

27 yrs. *11* mos. *11* ds.

IF LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife.

9-BIRTHPLACE, (State or Country),

Balto. Md.

10-NAME OF FATHER,

John Weigel

11-BIRTHPLACE OF FATHER (State or Country),

Germany.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Samuel Myers

(Address)

2516 Ashton St.

AUG 13 1915

HARRY O. ANDREWS,

Filed

101

Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 11th 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, au-

Inquest and that said deceased came to *her* death (topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Acid Poisoning
suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Samuel Myers M. D.

Aug 12th 1915 (Address) *2302 Madison Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. *27* yrs. *11* mos. *11* ds.

Where was disease contracted, if not at place of death?

Western Cemetery

Former or usual residence *2516 Ashton St.*

19-PLACE OF BURIAL OR REMOVAL,

Western Cem

DATE OF BURIAL,

Aug 13 1915

20-UNDERTAKER

Robt. Brooks & Son Co

ADDRESS

2302 Madison Ave

No. 6. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87416

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87416

CERTIFICATE OF DEATH.

PLACE OF DEATH
OF BALTIMORE (No. *2227 Mondawmin*)
WARD *5*
2-FULL NAME *Mrs Mary E. Moore*
(Residence in Baltimore: No. *2227 Mondawmin* St. *Life* mos. *da.*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
6-DATE OF BIRTH, *Dec 28, 1848*
(Month) (Day) (Year)
7-AGE *66* yrs. *7* mos. *14* da. If LESS than 1 day, ...hrs. or...min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work... *House work*
(b) General nature of industry, business, or establishment in which employed (or employer)... *at home*
9-BIRTHPLACE, (State or Country), *Balt. City*
10-NAME OF FATHER, *Melchor Hasson*
11-BIRTHPLACE OF FATHER (State or Country) *Baltimore*
12-MAIDEN NAME OF MOTHER *Mary E. Muntz*
13-BIRTHPLACE OF MOTHER (State or Country), *Balt.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Addie Moore*
(Address) *2227 Mondawmin*

15-
AUG 13 1915
HARRY O. ANDREWS,
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 11, 1915*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquiry* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Acute Cardiac Dilatation
(Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY *Chronic Myocarditis*
(Secondary) (Duration) ... yrs. ... mos. ... ds.
(Signed) *Harry E. Andrews* (Coroner),
Aug 11, 1915 (Address) *3640 E. Canton*
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?...

Former or usual residence...
PLACE OF BURIAL OR REMOVAL, *Balto Cemetery*
DATE OF BURIAL, *Aug 12, 1915*
20-UNDERTAKER *A. Chubb*
ADDRESS *North*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87417

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *615 Columbia ave*)

2-FULL NAME *James Emory Poulton*

(Residence in Baltimore: No. *615 Columbia ave*)

120
ST. *W* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *44* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

June 12, 1841
(Month) (Day) (Year)

7-AGE

74 yrs. *1* mos. *30* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired Grocer

9-BIRTHPLACE
(State or country)

Baltimore

10-NAME OF FATHER

James Poulton

11-BIRTHPLACE OF FATHER
(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Susan Kelly

13-BIRTHPLACE OF MOTHER
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. E. Poulton Jr.
615 Columbia ave.

15-

AUG 13 1915.

Filed

HARRY O. ANDREWS

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

Aug 11th, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 6th, 1909 to *Aug 11th, 1915.*

that I saw him alive on *Aug 10th, 1915.*

and that death occurred, on the date stated above, at *7 A* m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) yrs. mos. ds.

Contributory

(SECONDARY)

Chronic Intestinal

(Duration) yrs. mos. ds.

(Signed)

J. E. Poulton Jr. M. D.
Aug 10th, 1915 (Address) *615 Columbia ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Mary's Church

DATE OF BURIAL

Aug 13, 1915

20-UNDERTAKER

St. Michael's Bros

ADDRESS

North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87418

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 S Chapel ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 125 S Chapel St.; 16 yrs., 6 mos., 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widow
(Write the word.)

6-DATE OF BIRTH, Feb. 5, 1850
(Month) (Day) (Year)

7-AGE, 64 yrs., 6 mos., 6 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

10-NAME OF FATHER, John Milchling

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eva Bauer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John Link

(Address) 125 S Chapel

15-AUG 13 1915 HARRY O. ANDREWS, REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 11, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1915, to Aug 11 1915, that I saw her alive on Aug 11 1915, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY Route. Renal Congestion
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Geo. Heller M. D.

Aug. 11, 1915 (Address) 193 Gough St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. Is the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Aug. 14, 1915

20-UNDERTAKER, Joe J. New 1914 C. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *7. E. Cr. Lombard & Spring* STE, *2* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
FULL NAME *Frederick Seitz*
(Residence in Baltimore: No. *No known residence* St. *60* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widowed* (Write the word.)
6-DATE OF BIRTH, *April 7th*, *1853* (Month) (Day) (Year)
7-AGE, *62* yrs., *4* mos., *4* ds. If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Painter*
(b) General nature of industry, business, or establishment in which employed (or employer), *General*
9-BIRTHPLACE, (State or Country), *Baltimore*
10-NAME OF FATHER, *Charles Seitz*
11-BIRTHPLACE OF FATHER (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER, *Mary J. Frater*
13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Mary A. Hanna*
(Address) *402 E. Biddle St.*

15- *AUG 13 1915*
F. H. *HARRY O. HARRIS*
191. *Harry O. Harris*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 11th*, *1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
(Duration) *...* yrs. *...* mos. *...* ds.

CONTRIBUTORY (Secondary) (Duration) *...* yrs. *...* mos. *...* ds.

(Signed) *J. W. Jones* M. D. (Coroner.)
Aug. 11., 1915 (Address) *316 Odumell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *...* yrs. *...* mos. *...* ds. In the State *...* yrs. *...* mos. *...* ds.

Where was disease contracted, if not at place of death? *...*

Former or usual residence *...*

19-PLACE OF BURIAL OR REMOVAL, *Western Cemetery* DATE OF BURIAL, *Aug 14., 1915*

20-UNDERTAKER, *Henry North* ADDRESS, *1301 E. Eager St.*

14. b.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph's Hospital*)

2-FULL NAME

Frank Dobrzycki (Dobrzycki)

(Residence in Baltimore: No. *528 S. Ann*)

REGISTERED No. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *9* yrs., *3* mos., *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Boy*

6-DATE OF BIRTH,

April 12th, 1906
(Month) (Day) (Year)

7-AGE,

9 yrs., *3* mos., *27* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

School Boy

9-BIRTHPLACE, (State or Country)

Baltimore Md

10-NAME OF FATHER,

Nikolay Dobrzycki

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Leonora Marcasawicz

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Leonora Dobrzycki*

(Address) *528 S. Ann*

15-

AUG 13 1915

HARRY O. ANDREWS,

Marital Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 12th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Shock) Run over by a portable soiler.

(Duration), ... yrs., ... mos., ... ds.

CONTRIBUTORY (Secondary) *Accident*

(Duration), ... yrs., ... mos., ... ds.

(Signed) *Elijah J. Russell* M. D.
(Coroner.)
Aug 13 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, ... yrs., ... mos., ... ds. State *9* yrs., *3* mos., *27* ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence *528 S. Ann*

19-PLACE OF BURIAL, OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Aug 13 1915

20-UNDERTAKER

William Fialkowski 1618 Eastern Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2401 Druid Hill Ave* St. *13* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *2401 Druid Hill Ave* St.; *25* yrs., *—* mos., *—* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH.

Oct 2, 1874
(Month) (Day) (Year)

7-AGE.

40 yrs., *10* mos., *9* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House-work

9-BIRTHPLACE.

(State or Country).

Pennsylvania

10-NAME OF FATHER.

Samuel Shue

11-BIRTHPLACE OF FATHER.

(State or Country).

Pennsylvania

12-MAIDEN NAME OF MOTHER.

Sarah Flickinger

13-BIRTHPLACE OF MOTHER.

(State or Country).

Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Charles H. Edwards

(Address).

2401 Druid Hill Ave

15-

AUG 13 1915

HARRY O. ANDREWS,

Filed.

191.

Burial Permit.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 11, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 9 1915, to *Aug 11 1915*,that I saw *her* alive on *Aug 10* 1915,and that death occurred, on the date stated above, at *1:45* pm.

The CAUSE OF DEATH* was as follows:

Exhaustion and air hunger(Duration)..... yrs..... mos. *10* ds.

CONTRIBUTORY.

(Secondary)

Pulmonary Tuberculosis (Duration)..... yrs..... mos. *6* ds.(Signed)..... *W. J. Hilley* M. D.*8/12*, 1915 (Address)..... *6 E. North St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSFERS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Jefferson York Co. Pa

DATE OF BURIAL.

AUG 14 1915

20-UNDERTAKER

ARMSTRONG DENNY CO.

ADDRESS

*715 Light St**W. J. Hilley M.D.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 Bartlett Ave ST. 9 WARD)

2-FULL NAME

(Residence in Baltimore: No. 623 Bartlett Ave St. 9 yrs. 7 mos. 5 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH

Jan 7, 1915
(Month) (Day) (Year)

7-AGE

7 yrs. 5 mos. 5 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Balt.

10-NAME OF FATHER

Phillip G. Jeffers

11-BIRTHPLACE OF FATHER (State or Country),

Balt.

12-MAIDEN NAME OF MOTHER

Emma Sephard

13-BIRTHPLACE OF MOTHER (State or Country),

Balt.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Phillip G. Jeffers
(Address) 623 Bartlett Ave

15-

AUG 13 1915

HARRY O. ANDREWS,

Filed..... 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 12, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 11 1915, to Aug 12 1915, that I saw her alive on Aug 11 1915, and that death occurred, on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Infection

(Duration)..... yrs..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos. 4 ds.

(Signed)..... Russell M. D.

8/12/15, 1915 (Address) 623 Bartlett Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos. 4 ds. In the State..... yrs..... mos. 4 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

Western Cemetery

DATE OF BURIAL

Aug 13 1915

20-UNDERTAKER

Rolt S. Turner

ADDRESS

1442 N. Brady

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87421

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87421

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1928 Ething*)

ST. *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME *Judy Walker*

(Residence in Baltimore: No. *1928 Ething St*)

St. *13* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*

4 COLOR OR RACE *Colored*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

Widow

6 DATE OF BIRTH

Unknown, 1870
(Month) (Day) (Year)

7 AGE

45 yrs. mos. ds. or min. 7

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

*Janitor
Office Bldg.*

9 BIRTHPLACE (State or country)

St Mary Co Md

10 NAME OF FATHER

John Sayler

11 BIRTHPLACE OF FATHER (State or country)

St Mary Co Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

St Mary Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Walker

(Address)

1928 Ething St

15 AUG 13 1915

HARRY O. ANDREWS,
Marital Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 12, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug 4, 1915 to Aug 12, 1915

that I saw him alive on *Aug 12, 1915*

and that death occurred, on the date stated above, at *2:50 P.M.*

The CAUSE OF DEATH* was as follows:

Bright disease

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *J. A. McLean* M. D.

Aug 12, 1915 (Address) *1503 N. North St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

Aug 13, 1915

20 UNDERTAKER

ADDRESS

Felix B. Pyle

102 E. Mulberry St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St Josephs Hospital* ST. *9* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Elizabeth S. Liff*
(Residence in Baltimore: No. *St Josephs Hospital* St. yrs., - mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH, *Aug 24, 1896*
(Month) (Day) (Year)
7-AGE, *18* yrs., *11* mos., *12* ds. If LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer), *at home*

9-BIRTHPLACE.
(State or Country), *md*

10-NAME OF FATHER, *John S. Liff*
11-BIRTHPLACE OF FATHER, (State or Country), *md*
12-MAIDEN NAME OF MOTHER, *Eva Simpson*
13-BIRTHPLACE OF MOTHER, (State or Country), *md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John S. Liff*
(Address) *Roslyn md*

15-AUG 13 1915

HARRY O. ANDREWS,

Filed, 1915, *1st Permit Clerk*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 18, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

Inquiry and that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns of 2nd degree

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) *Gasoline Explosion*

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Elijah S. Russell* M. D. (Coroner.)

Aug 12, 1915 (Address) *473 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, ... yrs. ... mos. *6* ds. In the *18* yrs., *11* mos., *12* ds.

Where was disease contracted, if not at place of death? *Roslyn md*

Former or usual residence *Roslyn md*

19-PLACE OF BURIAL OR REMOVAL, *Mt. Oliv Cem* DATE OF BURIAL, *Aug 14, 1915*

20-UNDERTAKER, *Joe B. Cook* ADDRESS, *1003 W. Balt St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87426

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *826 N Fulton Ave* St. *16* WARD)

2-FULL NAME

Residence in Baltimore: No. *826 N Fulton Ave* St. *Life time* mos. *16* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

*MARRIED**WIDOWED**OR DIVORCED**(Write the word.)**Married*

6-DATE OF BIRTH

April 4th

(Month)

(Day)

(Year)

7-AGE,

*62**4**7**ds.*

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

*Henry Klebenape**Germany**Mary Kurbine**Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*Mrs. Wm. G. Mottlie**826 N. Fulton Ave*

15-

Filed

*AUG 13 1915**HARRY O. ANDREWS*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 11th

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 1914*, to *date of death* that I saw h^e alive on *Aug 11th 1915*, and that death occurred, on the date stated above, at *8:30* m.

The CAUSE OF DEATH* was as follows:

Death was the result of carcinoma of uterus of about 6 mos. duration.

CONTRIBUTORY (Secondary)

Chronic Myocarditis(Signed) *John E. Davis* M. D. *Aug 12 1915* (Address) *824 N. Fulton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDE, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*Cathedral Cemetery**AUG 13 1915*

20-UNDERTAKER

Geo. A. Gerby

ADDRESS

*Baltimore**Pinkney I Davis M.D.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87427

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87427

1 PLACE OF DEATH

104 REGISTERED NO. C

CITY OF BALTIMORE (No.

117 Garrison Lane

ST.

70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and tent No. 18.)

2-FULL NAME

Cecil Cabot Anderson Jr.

(Residence in Baltimore: No.

117 Garrison Lane

Sr.;

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

single

6-DATE OF BIRTH

Feb.

4,

1915

(Month)

(Day)

(Year)

7-AGE

6

mos.

8

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE

(State or country)

Maryland

10-NAME OF FATHER

Cecil Cabot Anderson

11-BIRTHPLACE OF FATHER

(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Emmaloune Murdock

13-BIRTHPLACE OF MOTHER

(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emmaloune L. Anderson

(Address)

117 Garrison Lane

15-

AUG 13 1915

FILED

HARRY O. ANDREWS

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug-

12,

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

Aug 8 -

1915,

to,

Aug 12 - 1915,

that I saw him alive on

Aug 11 -

1915,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus

Contributory (SECONDARY)

Acute Enteritis

(Signed)

E. Heller M. D.

Aug 12, 1915

(Address) 2000 Hollister St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Western Cemetery

DATE OF BURIAL

Aug 13, 1915

20-UNDERTAKER

F. B. Whipple

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087428

HEALTH DEPARTMENT—CITY OF BALTIMORE

087428

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *University Hospital* ST. *71* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1413 Columbia Ave* St.; yrs. *21* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH,

May 15th 1884

7-AGE

26 yrs. *2* mos. *28* ds.

IF LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Iron Menial

1720 Railroad

9-BIRTHPLACE,

(State or Country).

Berroll Co, Md.

10-NAME OF FATHER,

Horton

11-BIRTHPLACE OF FATHER

(State or Country).

Md.

12-MAIDEN NAME OF MOTHER

Annie Seatz

13-BIRTHPLACE OF MOTHER

(State or Country).

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Helda G. Horton*

(Address) *1413 Columbia Ave*

15-

AUG 13 1915

O. ANDREWS,

Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

August 12th 1915

17-

I HEREBY CERTIFY, That I took charge of the

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HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *1119 Carroll*)

2-FULL NAME

Wilhelmina Strach(Residence in Baltimore: No. *1119 Carroll*)

REGISTERED NO. C

ST. *21* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out Nos. 18.)

St.; *40* yrs., — mos. — ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widowed

6-DATE OF BIRTH,

Dec. 26th, 1841
(Month) (Day) (Year)

7-AGE,

73 yrs. 7 mos. 17 ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

House Duties

(b) General nature of industry, business, or establishment in which employed (or employer)...

At Home

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Unknown Schultz

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Reinhold A. Strach*(Address) *1119 Carroll St.*

15-AUG 13 1915

HARRY O. ANDREWS,

Filed..... 1915

Special Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 12th, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Aug 6* 1915 to *Aug 12* 1915 that I saw her alive on *Aug 12* 1915, and that death occurred, on the date stated above, at *2:30* p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

CONTRIBUTORY (Secondary)

Family(Signed) *John H. Schwab* M. D.*Aug 12, 1915* (Address) *1120 W. Cross St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL,

Aug. 15th, 1915

20-UNDERTAKER

Mrs. John H. Teufel & Co. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

1 PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED No. C.

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.

Yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

IF LESS than

1 day,

hrs.

min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *15* WARD)

2-FULL NAME *Odene B. Hodge*

(Residence in Baltimore: No. *3417 Mondawmin Ave.* St. *6* yrs. *6* mos. *6* ds.)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE MARRIED WIDOWED OR DIVORCED *Single*
6-DATE OF BIRTH *February 23rd 1915*
(Month) (Day) (Year)
7-AGE *6* yrs. *6* mos. *6* ds. or *11* hrs. *20* min.?
8-OCCUPATION *None*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore - Md.*

10-NAME OF FATHER *Ramsay Hodge*
11-BIRTHPLACE OF FATHER (State or country) *Maryland*
12-MAIDEN NAME OF MOTHER *Lucy Duckett*
13-BIRTHPLACE OF MOTHER (State or country) *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *P. B. Bessel*

(Address) *Johns Hopkins Hospital*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August 12th 1915*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *April 13th 1915* to *August 12th 1915*, that I saw him alive on *August 12th 1915*, and that death occurred, on the date stated above, at *11:30 p.m.*
The CAUSE OF DEATH* was as follows:

Pyloric stenosis

Contributory (SECONDARY) *Pneumonia*

(Signed) *Alma S. Rotholz* M.D.
August 12th 1915 [Address] *Johns Hopkins Hospital*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *1* yrs. *1* mos. *1* ds. In the *1* yrs. *1* mos. *1* ds. State

Where was disease contracted, if not at place of death?

Former or usual residence *3417 Mondawmin Ave.*

19-PLACE OF BURIAL OR REMOVAL *Chesapeake & Atlantic Md*

DATE OF BURIAL *Aug 13 1915*

20-UNDERTAKER *W. B. Fuller*

ADDRESS *221 N Broadway*

Filed *14* 1915

REGISTRAR

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87432 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH **Hahnemann General Hospital,**
CITY OF BALTIMORE (No. **1122 N. Mount street,** ST. **12** WARD)
2-FULL NAME **Lillian Johnson,**
(Residence in Baltimore: No. **405 E. 25th Street,** St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

unknown
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. **Female,** 4-COLOR OR RACE, **Colored,** 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, **Single,** (Write the word.)
6-DATE OF BIRTH, **Unknown,** / (Month) (Day) (Year)
7-AGE, **23?** yrs. **?** mos. **?** ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. **Servant,**
(b) General nature of industry, business, or establishment in which employed (or employer) **House work,**
9-BIRTHPLACE, (State or Country), **Probably Virginia,**
10-NAME OF FATHER, **Unknown,**
11-BIRTHPLACE OF FATHER (State or Country), **Unknown,**
12-MAIDEN NAME OF MOTHER **Unknown,**
13-BIRTHPLACE OF MOTHER (State or Country), **Unknown,**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) **No informant,**
(Address)

15- **9161** **Chas. M. Sudaer**
Filed. 191 **Registrar.**

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, **August 4th, 1915.**
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an **autopsy** (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said **autopsy** (Inquest, autopsy or inquiry.)
and that said deceased came to **her** death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis,
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Signed) **J. Frederick Hampel** M. D. (Coroner.)
Aug. 5th, 1915. (Address) **3310 W. North ave.**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death **22 hours,** In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, **PUBLIC CEMETERY,** DATE OF BURIAL, **AUG. 13 1915**
20-UNDERTAKER **Commissioner Health,** ADDRESS

Per. Wm. E. WOODALL

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87431

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87431

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Proclaimed dead Meray Hospital* 12
CITY OF BALTIMORE (No. ST. WARD)
2-FULL NAME *Charles Snowden*
(Residence in Baltimore: No. *1811 Guilford Place* St.; yrs. mos. *35* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH, (Month) (Day) (Year) *1*
7-AGE, (Yrs.) (Mos.) (Dss.) *35* If LESS than 1 day, (hrs.) or (min.)
8-OCCUPATION: (a) Trade, profession, or particular kind of work *Child* (b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country) *City*
10-NAME OF FATHER
11-BIRTHPLACE OF FATHER (State or Country)
12-MAIDEN NAME OF MOTHER
13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Police Records*
(Address)

15- *AUG 14 1915* *Chas M. Audair*
Filed 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July* 1915 (Month) (Day) (Year)
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows: *Convulsions following accidental fall from bed*
(Duration) (yrs.) (mos.) (ds.)
CONTRIBUTORY (Secondary) (Duration) (yrs.) (mos.) (ds.)
(Signed) *W. H. Kauter* M. D. (Coroner.)
July 20 1915 (Address) *1811 Guilford Place*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death (yrs.) (mos.) (ds.) In the State (yrs.) (mos.) (ds.)

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

PUBLIC CEMETERY *AUG 13 1915*

20-UNDERTAKER ADDRESS

Commissioner Health,

Per. Wm. E. WOODSALL.

C87435

RE 92 087435

CITY OF BALTIMORE: (NO. 232 Roberts ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 222 10th Street Ct St. yrs. mos. ds)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *July 21st*, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19 1915, to July 21 1915
that I saw him alive on July 21 1915
and that death occurred, on the date stated above, at 6 PM

The CAUSE OF DEATH* was as follows:

Total Presences.....

(Duration)..... yrs..... mos. 3 ds.

CONTRIBUTORY.....
(Secondary)

(Duration) yrs. mos. da.
(Signed) M. D.
21240, 191. (Address) 417 N. Carroll

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	hrs.	mos.	ds.	In the State	hrs.	mos.	ds.
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Where was disease contracted,
if not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,
PUBLIC CEMETERY, AUG. 13. 1915, 191...

20-UNDERTAKER
Missouri Health.

ADDRESS

Prof. Wm. E. Woodall

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day. hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Accident, Fall from height, fracture of skull.

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

PUBLIC CEMETERY

20-UNDERTAKER

Commissioner Health,

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

522 Eisten

Mary Brown

522 Eisten

ST.

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widow

6-DATE OF BIRTH

Unknown

1867

7-AGE

48

It LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laundress

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ornest Brown

(Address)

522 Eisten

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

27th, 1915

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, su-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart-disease

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Mrs. M. Savage, M. D.

(Coroner.) July 28, 1915 (Address) 1729 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PUBLIC CEMETERY OR REMOVAL,

AUG 13 1915

20-UNDERTAKER Health, Commissioner

ADDRESS

AUG 14 1915

Chas. M. Sinclair

Registrar.

Per. Wm. E. WOODALL

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Ludwig Belinski* ST.;

yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

Not known, 1
(Month) (Day) (Year)

7-AGE,

45?

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Steward
*Coal Pier*9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Board Mercy Hosp*(Address) *Robert St.*

15-

Filed *Aug 14 1915*

191.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 31, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 9 191*5*, to *July 31* 191*5*,that I saw him alive on *July 31* 191*5*and that death occurred, on the date stated above, at *1157* m.

The CAUSE OF DEATH* was as follows:

*Myocarditis**Heart* (Duration) *27* yrs. *7* mos. *7* ds.CONTRIBUTORY
(Secondary)*Heart* (Duration) *27* yrs. *7* mos. *7* ds.(Signed) *Edward D. Smith* M. D.*July 31*, 191*5*. (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *27* yrs. *7* mos. *7* ds. In the State *Denot Long*Where was disease contracted, if not at place of death? *Sparrows Point Md.*Former or usual residence *Sparrows Point Md.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

PUBLIC CEMETERY

AUG 13 1915

20-UNDERTAKER

Commissioner Health,

ADDRESS

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Morgan

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH
CITY OF BALTIMORE (No. *155* ST. *B* WARD)
2-FULL NAME *Joseph M. Gaughlin*
(Residence in Baltimore: No. *unknown lodging houses* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

not known
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH, *1* (Month) (Day) (Year)
7-AGE, *about 45* yrs. mos. ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer). *Ground*

9-BIRTHPLACE, (State or Country), *England*

PARENTS.
10-NAME OF FATHER, *?*
11-BIRTHPLACE OF FATHER (State or Country), *?*
12-MAIDEN NAME OF MOTHER, *?*
13-BIRTHPLACE OF MOTHER (State or Country), *?*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Police Records*
(Address) *Police Records*

15-
Filed *Aug 14 1915*
Chas M. Sweeney
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 28*, 191*5*.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Carbonic acid by mouth

(Duration) *few minutes*

CONTRIBUTORY (Secondary)

(Signed) *W. H. Chamberlain* M. D. (Coroner.)
July 28, 191*5*. (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *dead* In the *5* yrs. mos. ds. State *5* yrs. mos. ds.

Where was disease contracted, if not at place of death? *804 E. Pratt St*

Former or usual residence *?*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL, *AUG 13 1915*

PUBLIC CEMETERY
TO UNDERTAKER Health, *Commissioner*

ADDRESS

W. E. WOODALL

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street & number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

April 10, 1872

7-AGE

43 yrs. 4 mos. 3 ds. or less than 1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Supt. Balto. Orphan Asylum
until last illness.

9-BIRTHPLACE

(State or country)

Baltimore, Md.

10-NAME OF FATHER

Wm. J. Price

11-BIRTHPLACE OF FATHER (State or country)

Virginia, U.S.A.

12-MAIDEN NAME OF MOTHER

Sarah A. Sayre

13-BIRTHPLACE OF MOTHER (State or country)

New York, N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter P. Lomas

(Address)

2836 Clifton Ave

15.

AUG 14 1915

Filed

191

HARRY O. ANDREWS,

Serial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 13, 1915

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1914, to Aug. 12, 1915.

that I saw her alive on August 12, 1915, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Indefinite

Contributory (SECONDARY)

Indefinite

(Signed)

Aug 13, 1915 (Address) 1416 W. Lawrence St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Round Park Aug 15, 1915

20-UNDERTAKER

Edw. Mitchell Edw. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *1629 Cuba* ST. *24* WARD)

REGISTERED NO. C

2-FULL NAME *Fannie E. Oliver*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1629 Cuba Street* St.: yrs. *1* mos. *21* da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. *Female*4-COLOR OR RACE. *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)6-DATE OF BIRTH, *June 21, 1915*

(Month)

(Day)

(Year)

7-AGE, *1* yrs. *21* mos. *21* da.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Child*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER *William E. Oliver*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Margaret White*13-BIRTHPLACE OF MOTHER (State or Country), *England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Margaret Oliver*(Address) *1629 Cuba St.*

15-AUG 14 1915

Filed....., 191.....

HARRY O. ANDREWS,

Serial Form 10-1-14

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 12, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 1, 1915*, to *Aug 12, 1915*, that I saw her alive on *Aug 11, 1915*, and that death occurred, on the date stated above, at *12 P.M.* The CAUSE OF DEATH* was as follows:*Bacterial enteritis*(Duration).....yrs.....mos. *14* da.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....da.

(Signed) *Therese Jones* M. D.*Aug 14, 1915*. (Address) *423 E. Fort Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....da. In the.....yrs.....mos.....da. State.....

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Cedar Hill*DATE OF BURIAL, *Aug 14, 1915*20-UNDERTAKER *William Cook*ADDRESS *5026 North Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87442

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87442

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *406. Grinnall St.* ST. *24* WARD)

2-FULL NAME

Marion Melchor Johnson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *406. Grinnall St.*

St. *8* yrs. *7* mos. *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

Aug
(Month)

20
(Day)

1906
(Year)

7-AGE

8 yrs. *7* mos. *18* ds.

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or country)

Baltimore

10-NAME OF FATHER

Benj. F. Johnson

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Jan M. Williams

13-BIRTHPLACE OF MOTHER
(State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Benj. F. Johnson

(Address)

406. Grinnall St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug
(Month)

12
(Day)

1915
(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 12, 191*5*, to, *Aug 12*, 191*5*

that I saw *her* alive on *Aug 12*, 191*5*

and that death occurred, on the date stated above, at *1:45 P.M.* hr.

The CAUSE OF DEATH* was as follows:

Myocardial Stenosis.

(Duration) *3* yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *Edw. Smith* M.D.

Aug 13, 191*5* [Address] *910 Light St*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

Aug 15, 191*5*

20-UNDERTAKER

William Cook

ADDRESS

502 E. North

AUG 14 1915

Filed 1915

HARRY O. ANDREWS,

Married Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy*

ST.:

WARD) *14*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Alice Brooks(Residence in Baltimore: No. *St. Vincent's Infant Asylum*

St.:

yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *single*

6-DATE OF BIRTH,

*Aug.**10th**1915*

(Month)

(Day)

(Year)

7-AGE,

If LESS than 1 day.

8 hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

St. Vincent's

(Address).....

1401 Division St.

15-

AUG 14 1915

HARRY O. ANDREWS,

Baptist Parish Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*August**10th**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

August 10th 1915

to

191

that I saw h alive on

*191*and that death occurred, on the date stated above, at *500 P. m.*

The CAUSE OF DEATH* was as follows:

Congenital debility

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....*E. H. Hayward*.....M. D.*Aug. 11., 1915.* (Address) *E. B. E. Preston, St.**per John A. Maxwell*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. *8 mos.* In the State yrs. mos. *8 mos.* ds.Where was disease contracted, if not at place of death? *St. Vincent's Inf. Asylum*Former or usual residence *St. Vincent's Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral City Aug 14, 1915

20-UNDERTAKER

ADDRESS

St. Fahy & Sons, 606 E. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Vincent's Infirmary* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Edward Baker(Residence in Baltimore: No. *St. Vincent's Infirmary* St.; yrs., *5* mos. *23* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

February 20, 1915
(Month) (Day) (Year)

7-AGE,

5 yrs., 23 mos., 23 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

AUG 14 1915

HARRY O. ANDERSON

Filed

191

BALTIMORE, MARYLAND
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 12th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *August 9th 1915*, to *August 12 1915*, that I saw him alive on *August 12th 1915*, and that death occurred, on the date stated above, at *2.30 P.m.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. *4* ds.(Signed) *J. H. Boulton* M. D.*Aug 13., 1915.* (Address) *15 Columbia*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *5* mos. *23* ds. In the State yrs. *5* mos. *23* ds.Where was disease contracted, if not at place of death *St Vincent's Infirmary*Former or usual residence *St Vincent's Infirmary*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral *Aug 14., 1915*

20-UNDERTAKER

ADDRESS

M. Baker & Sons 606 Fayette

ee Birth Certificate of Joseph Rice,
orn Apr. 21st. 1915
B-11731

hich is the American Name,
for Rackanokas.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

C87445

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 Portland

ST.: 22 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Rackanokas

(Residence in Baltimore: No. 700 Portland

St.; yrs., 3 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE. white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. April 20, 1915 (Month) (Day) (Year)

7-AGE. 3 yrs., 3 mos., 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), Baltimore

10-NAME OF FATHER, Joseph Rackanokas

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Mary Kupcinkas

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Joseph Rackanokas

(Address), 700 Portland St.

15-AUG 14 1915 HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 13, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 11, 1915, to Aug 13, 1915, that I saw him alive on Aug 12, 1915, and that death occurred, on the date stated above, at 5 a m. The CAUSE OF DEATH* was as follows:

Gastro Enteric Obstruction

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pykemia

(Duration) yrs. mos. 3 ds.

(Signed), J. M. Lempert, M. D.

Aug 13 1915 (Address), 826 S. Carroll St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Stanislaus Aug 14, 1915

20-UNDERTAKER, ADDRESS

John Brebliunas 500 S. Paca

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *859 Hallins* ST. *18* WARD) REGISTERED No. C
2-FULL NAME *Adela Mauchis*
(Residence in Baltimore: No. *859 Hallins* Sm³ yrs., 10 mos. *28* ds.)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)
6-DATE OF BIRTH, *Sept. 21, 1911*
(Month) (Day) (Year)

7-AGE, *3* yrs., *10* mos., *23* ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balto, Md.*

PARENTS.
10-NAME OF FATHER, *Vincent Mauchis*
11-BIRTHPLACE OF FATHER (State or Country), *Russia*
12-MAIDEN NAME OF MOTHER, *Ella Glaviatzki*
13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Vincent Mauchis*
(Address) *859 Hallins*

15-
AUG 14 1915 HARRY O. ANDREWS,
REGISTRAR.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 13th, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry*
(Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock and internal injuries, the result of an accidental fall from the third story window down to pavement.
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) *Miss McSavage*
Aug. 13, 1915 (Duration) ... yrs. ... mos. ... ds.
(Signed) *Miss McSavage* M. D.
(Coroner.)
Aug. 13, 1915 (Address) *1729 Madison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer* DATE OF BURIAL, *Aug. 15, 1915*

20-UNDERTAKER, *John Grechianakis* ADDRESS, *500 S. Paca St.*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *210 S. High*)

2-FULL NAME *Otto L. Monril (Monril)*

(Residence in Baltimore: No. *210 S. High*)

184

REGISTERED No. C

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., *12* — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)

6-DATE OF BIRTH, *June 12th, 1873* (Month) (Day) (Year)

7-AGE, *42 yrs. 2 mos. — da.* If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Lodging House Keeper* (b) General nature of industry, business, or establishment in which employed (or employer), *210 S. High St.*

9-BIRTHPLACE, (State or Country), *Nova Scotia*

10-NAME OF FATHER, *Samuel Monril*

11-BIRTHPLACE OF FATHER (State or Country), *Nova Scotia*

12-MAIDEN NAME OF MOTHER *Sarah Jane Richards*

13-BIRTHPLACE OF MOTHER (State or Country), *Nova Scotia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Samuel Monril*

(Address), *1709 E. Pratt St.*

15-AUG 14 1915

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 12th, 1915* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion of the Brain
Homicidal due to a blow
(Duration).....yrs.....mos.....da.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....da.
(Signed) *David W. Jones* M. D. (Coroner.)
Aug. 14th, 1915 (Address) *3116 O'Donnell St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death.....yrs.....mos.....da. State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oak Lawn Cem.

Aug. 14 1915

20-UNDERTAKER

ADDRESS

H. Vander Lous

1710 Bleeker

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87448

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87448

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1105 S. Robinson*)

ST. *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Peter McFaul

(Residence in Baltimore: No. *1105 S. Robinson*)

St. *10* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widowed

6-DATE OF BIRTH

March 17, 1845
(Month) (Day) (Year)

7-AGE

70 yrs. *4* mos. *26* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

*Retired
Carpenter*

9-BIRTHPLACE
(State or country)

Ireland

10-NAME OF FATHER

Alexander McFaul

11-BIRTHPLACE OF FATHER
(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

McFaul

13-BIRTHPLACE OF MOTHER
(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. O. McFaul
(Address) *1105 S. Robinson St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 13, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

January 15, 1914, to *August 13, 1915*,
that I saw him alive on *August 12, 1915*,
and that death occurred, on the date stated above, at *9 P.* m.

The CAUSE OF DEATH* was as follows:

*No operation. Cancer of left side of
face*

(Duration) *1* yrs. *7* mos. *28* ds

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

David W. Jones M. D.
Aug 14, 1915 (Address) *3116 Cornwell*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross Church

Aug 16, 1915

20-UNDERTAKER

ADDRESS

H. Sander

1710 Reed St

AUG 14 1915

Filed

191

HARRY O. ANDREWS,

CORRECTIONAL CLERK

REGISTRAR

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087449

HEALTH DEPARTMENT—CITY OF BALTIMORE

087449

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *826 Herman Court* ST. *10* WARD *79*)

2-FULL NAME

Mary Jones

(Residence in Baltimore: No. *826 Herman Court*)

St. *7* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

Widow
(Write the word.)

6-DATE OF BIRTH,

Unknown, *1*

(Month)

(Day)

(Year)

7-AGE,

46

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

At Home

9-BIRTHPLACE,

(State or Country),

Pa

10-NAME OF FATHER,

John Sutton

11-BIRTHPLACE OF FATHER

(State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ada Jones*

(Address) *826 Herman Ct*

15-

Filed *AUG 14 1915*

191

HARRY O. ANDREWS,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug

11

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

inquest and that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Robert H. Russell* M. D.

Aug 11 1915 (Address) *433 N. Broadway*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel Cemetery

Aug 16 1915

20-UNDERTAKER

ADDRESS

Charles B. Jones

1111 N. Saratoga

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hosp.* ST. *12* WARD)

2-FULL NAME

(Residence in Baltimore: No. *406-W 29th* St.; — yrs., — mos., — ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white

5-SINGLE,

*MAILED**single**OR DIVORCED,**(Write the word.)*

6-DATE OF BIRTH,

unknown, *1859*
(Month) (Day) (Year)

7-AGE,

56

yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*operator in**Cotton Mills*

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Elisha Ebaugh

11-BIRTHPLACE OF FATHER,

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER,

Catherine Hikes

13-BIRTHPLACE OF MOTHER,

(State or Country),

Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles Shaffer*(Address) *406 W 29th St.*

15-

Filed

*1915**HARRY O. ANDREWS,**Registrar.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. *11*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 10 *1915*, to *Aug 11* *1915*that I saw her alive on *Aug 11* *1915*and that death occurred, on the date stated above, at *3:45 P.* m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

CONTRIBUTORY (Secondary)

Post operative shock(Signed) *A. S. Coleman* M. D.*Aug 11*, *1915* (Address) *University City Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *1* ds. *56* In the State yrs. mos. ds.Where was disease contracted, if not at place of death? *Former Residence*Former or usual residence *406-W 29th St.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Freelande, *Baltimore*, *Aug 15*, *1915*20-UNRECORDED ADDRESS *Ed. Stuffer* *847 W 36th St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: ... WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

AUG 14 1915

HARRY O. ANDREWS,

BARTER PERMIT CLERK
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

July 20 1915, to August 11 1915.
that I saw him alive on August 11 1915,
and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

Aug 12 1915. (Address) T. & E. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

73
20 clock
87452
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *404 N Broadway* St. *6* WARD)

2-FULL NAME *Helena M Lenhardt*

(Residence in Baltimore: No. *404 N Broadway*

REGISTERED NO. C. *172*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *78* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH, *Oct 5th, 1830*
(Month) (Day) (Year)

7-AGE, *84* yrs., *10* mos., *7* ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

PARENTS.
10-NAME OF FATHER, *Germany*
11-BIRTHPLACE OF FATHER (State or Country), *Prussia*
12-MAIDEN NAME OF MOTHER, *Prussia*
13-BIRTHPLACE OF MOTHER (State or Country), *Prussia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. John Bremer*

(Address) *404 N Broadway*

15- *AUG 14 1915* HARRY O. ANDREWS, *Greenmount Cemetery*
Filed *14* Mort. *Clark* 20-UNDERTAKER *Wm C Fuller*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 12th, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said *Inquest*, find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

CONTRIBUTORY (Secondary) *Fractured Femur*
(Accident) *Fell up bed room*
(Signed) *Elijah J. Russell* M. D. (Coroner)
Aug 15, 1915 (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Greenmount Cemetery* DATE OF BURIAL, *Aug 16th 1915*

20-UNDERTAKER *Wm C Fuller* ADDRESS *221 N Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2306 Etting*ST.: *14* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *2306 Etting*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *70* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Caucasian*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *?*

6-DATE OF BIRTH,

unknown

(Month)

(Day)

(Year)

7-AGE,

70

yrs.

mos.

ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Labour

(b) General nature of industry, business, or establishment in which employed (or employer).

General

9-BIRTHPLACE,

(State or Country).

North Carolina

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER

(State or Country).

unknown

12-MAIDEN NAME OF MOTHER

(State or Country).

unknown

13-BIRTHPLACE OF MOTHER

(State or Country).

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Charles Chaney

(Address)

2306 Etting St

15-

AUG 14 1915

Filed

191

HARRY O. ANDREWS,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 13, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 10, 1915*, to *Aug 13, 1915*, that I saw him alive on *Aug 10th, 1915*, and that death occurred, on the date stated above, at *8 a.m.*

The CAUSE OF DEATH* was as follows:

Nephritis Acute

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Heart Failure

(Duration) yrs. mos. ds.

(Signed) *H. J. Smith* M. D.*8-14, 1915* (Address) *354 N. D. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Int. Auburn Cemetery

DATE OF BURIAL,

Aug 15, 1915

20-UNDERTAKER

Scott Hooper

ADDRESS

40 Littleton St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1216 Linden Ave St. 11

WARD)

2-FULL NAME

Joseph P Webster

(Residence in Baltimore: No. 1216 Linden Ave St. 5

yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widowed

6-DATE OF BIRTH

Sept, 1885 (Month) (Day) (Year)

7-AGE

80 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Retired

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

James R. Webster

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Evan Mitchell

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. H. Sadler

(Address)

226 N. Liberty St

15

HARRY O. ANDREWS,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug. 13, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from

Aug. 13, 1915, to Aug. 13, 1915,

that I saw him alive on Aug. 13, 1915,

and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

(over) Exhaustion

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

Uræmic Convulsion

(Duration) yrs. mos. ds.

(Signed)

Barrett B. Gathin M.D.

Aug. 14, 1915 (Address) 1404 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Landen Park

DATE OF BURIAL

Aug. 16, 1915

20 UNDERTAKER

E. M. Mite Lell & Co.

ADDRESS

1201 W. Fayette

Filed AUG 14 1915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1437 myrtle ave* ST. *17* WARD)2-FULL NAME *Priscilla Jane Gray*(Residence in Baltimore: No. *1437 myrtle ave* St. *17* yrs. *6* mos. *6* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Colored*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *June 15 1915*

(Month) (Day)

7-AGE, *7 1/2*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer)... *at home*9-BIRTHPLACE, (State or Country), *Calvert Md*10-NAME OF FATHER, *Augustus King*11-BIRTHPLACE OF FATHER (State or Country), *Calvert Md*12-MAIDEN NAME OF MOTHER, *Rebecca Parker*13-BIRTHPLACE OF MOTHER (State or Country), *Calvert Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Susan T. Gray*(Address) *1437 Myrtle Ave*

15-

AUG 14 1915

HARRY O. ANDREWS,

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 14 1915*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 15 1915* to *Aug 13 1915*, that I saw him alive on *Aug 13 1915*, and that death occurred, on the date stated above, at *4:30* m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORS (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Dr. J. H. B. Biddle*(Address) *1437 Myrtle Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Harvard St. Calvert Md**Aug 14 1915*

20-UNDERTAKER

ADDRESS

*Samuel H. Hensley**578 W. Biddle*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2008 E. Eager* ST. *7* WARD)

2-FULL NAME

(Residence in Baltimore: No. *2008 E. Eager* St. *54* yrs. — mos. — ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *Oct 2, 1858*
(Month) (Day) (Year)

7-AGE, *56 yrs. 10 mos. 11 ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... *Butcher*
(b) General nature of industry, business, or establishment in which employed (or employer)... *Beef*

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *John Miller*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Fannie Miller*(Address) *2008 E. Eager*

15-

Filed *AUG 14 1915* HARRY O. ANDREWS,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 13th, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 16th, 1915* to *Aug 13th, 1915*, that I saw him alive on *Aug 17th, 1915* and that death occurred, on the date stated above, at *12:30 a.m.*

The CAUSE OF DEATH* was as follows:

Natural Causes
(Duration) yrs. mos. *28* ds.

CONTRIBUTORY (Secondary) *Heart Disease*
(Duration) yrs. mos. *14* ds.

(Signed) *W. S. H. H. D.*
Aug 13th, 1915 (Address) *501 E. Eager*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer* DATE OF BURIAL, *Aug 16, 1915*

20-UNDERTAKER, *Philip Herwig* ADDRESS *2016 Orleans*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Joseph's Hospital* St. 1 yrs. - moa. 13 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

Married, widowed, or divorced, (Write the word.)

6-DATE OF BIRTH

May 13th 1871
(Month) (Day) (Year)

7-AGE

*45 yrs. 3 mos. da.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Housework
At Home*9-BIRTHPLACE,
(State or Country)*Germany*

10-NAME OF FATHER

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country)*Germany*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country)*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary J. Sellman*(Address) *420 S. 5th St.*

15-

HARRY O. ANDREWS,

AUG 14 1915
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

August 12, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 31* 1915, to *Aug 12* 1915, that I saw her alive on *Aug 12* 1915, and that death occurred, on the date stated above, at *11:50 P. M.*

The CAUSE OF DEATH* was as follows:

Typhoid Fever -
(Duration) yrs. mos. *17* da.CONTRIBUTORY
(Secondary)*Myocarditis*
(Duration) yrs. mos. *3* da.
(Signed) *Dean J. Pugh* M. D.
Aug 12, 1915 (Address) *St. Joseph's*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *13* da. In the *45* yrs. mos. da.Where was disease contracted, if not at place of death? *at 420 - 5th St.*Former or usual residence *420 - 5th St. Highlandtown Md*

19-PLACE OF BURIAL OR REMOVAL

Sacred Heart Cem. DATE OF BURIAL *Aug 16 1915*

20-UNDERTAKER

Philip Herwig ADDRESS *1016 Orleans*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. *John Hopkins Hospital* ST. *7* WARD)

2-FULL NAME

(Residence in Baltimore: No. *John Hopkins Hospital* St. *7* yrs. *7* mos. *7* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE MARRIED WIDOWED OR DIVORCED *Single* (Write the word)
6-DATE OF BIRTH *April 2nd* 1915 (Month) (Day) (Year)
7-AGE *4* yrs. *11* mos. *11* ds. or min. 2 If LESS than 1 day, hrs.
8-OCCUPATION (a) Trade, profession or particular kind of work *none* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

PARENTS

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

AUG 14 1915

HARRY O. ANDREWS,
Marial Permit Clerk.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1a-DATE OF DEATH

August 13th 1916- (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I attended deceased from *August 6th* 1915- to *August 3rd* 1915- that I saw him alive on *August 3rd* 1915- and that death occurred, on the date stated above, at *9¹⁰ a.m.*
The CAUSE OF DEATH* was as follows:

Intestinal degeneration

Contributory (SECONDARY)

(Signed)

August 13th 1915- [Address] *John Hopkins Hospital*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *7* yrs. *4* mos. *11* ds. In the State *4* yrs. *4* mos. *11* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. WARD

St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-AUG 14 1915

HARRY O. ANDREWS,
Marital Permit Clerk,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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C87460

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40
C87460

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1727 Guilford Ave 12

ST.

WARD)

2-FULL NAME Ellen Cohen

(Residence in Baltimore: No. 1727 Guilford Ave

St.

50 yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

June

25, 1837

(Month)

(Day)

(Year)

7-AGE

78

yrs.

1 mos.

18

ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work

Lady

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9-BIRTHPLACE

(State or country)

Charleston S. C.

10-NAME OF
FATHER

Moses Mordecai

11-BIRTHPLACE
OF FATHER

(State or country)

Charleston S. C.

12-MAIDEN NAME
OF MOTHER

Isabella Lyons

13-BIRTHPLACE
OF MOTHER

(State or country)

S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jacob J. Cohen

(Address)

1727 Guilford Ave

15

AUG 14 1915

HARRY O. ANDREWS

Serial Permit, City

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August

13

1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 7th

1915, to Aug 13

1915.

that I saw her alive on Aug 12

1915.

and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma

of the Stomach

No operation General Anesthesia

(Duration)

2

yrs.

mos.

ds.

Contributory (SECONDARY)

Dehydration

(Duration)

yrs.

mos.

8

ds.

(Signed)

Alfred Pallack

M. D.

Aug 13, 1915

(Address) 1112 Eutan St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence

In the

State

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cohen's Private Cemetery

8-15, 1915

20-UNDERTAKEN

Funeral Home

ADDRESS

Henry W. Jenkins Sons Co. 1112 Eutan St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87461

C87461

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Marland Genl Hospital*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2432 Inc Culloh St.*)St. *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Oct 25, 1904
(Month) (Day) (Year)

7-AGE,

*10 yrs. 10 mos. 2 ds.*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *School*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*Ignate Roth*11-BIRTHPLACE OF FATHER
(State or Country),*Europe*

12-MAIDEN NAME OF MOTHER

*Mary Schneider*13-BIRTHPLACE OF MOTHER
(State or Country),*Europe*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ignate Roth*(Address) *2432 Inc Culloh St.*

15-

AUG 14 1915

HARRY O. ANDREWS

Filed

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Social Permit Order

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

August 14, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 13* 1915, to *Aug 14* 1915, that I saw her alive on *Aug 13* 1915, and that death occurred, on the date stated above, at *2:45* A.M.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis (complicated by pelvic abscess)(Duration) *2* yrs. *2* mos. *1* ds.CONTRIBUTORY
(Secondary)*Acute Cardiac Dilatation*
(Duration) *3* yrs. *1* mos. *1* ds.(Signed) *William B Blanchard, M. D.*
8/14/15, 1915 (Address) *Ind. Gen Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *1* ds. In the State *10* yrs. *10* mos. *2* ds.Where was disease contracted, *2432 Inc Culloh St.*
if not at place of death?Former or usual residence *2432 Inc Culloh St.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Priestship Cem. 8/15, 1915

20-UNDERTAKER

ADDRESS

H. Sandheim 118 West Royal

(over)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1133 Watson ST. 3 WARD)

2-FULL NAME

William Clark(Residence in Baltimore: No. 1133 Watson

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

Colored
9.9.5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Married

6-DATE OF BIRTH,

Unknown, 1861
(Month) (Day) (Year)

7-AGE,

54 yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Laborer
General9-BIRTHPLACE,
(State or Country),md.

10-NAME OF FATHER,

Unknown11-BIRTHPLACE OF FATHER
(State or Country),Unknown

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Clark(Address) 1133 Watson St.

15-

AUG 14 1915

HARRY O. ANDREWS,

Filed..... 191.....

BALTIMORE CITY

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 12, 1915.
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1915, to Aug. 12, 1915, that I saw him alive on Aug. 12, 1915, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic pneumonia
(Duration) yrs. mos. 2 1/2 ds.CONTRIBUTORY
(Secondary)General debility
(Duration) yrs. mos. 1 1/2 ds.(Signed) J. C. RobertsAug. 13, 1915 (Address) 611 N. Calver St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Arbury Cemetery

DATE OF BURIAL,

Aug. 16, 1915.

20-UNDERTAKER

Wm. E. Elliott

ADDRESS

46 Piquette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1616 Kallieis* ST.; *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Elizabeth Ann Weaver*(Residence in Baltimore: No. *1616 Kallieis* St.; *15* yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-STATUS, *Widowed*
(Write the word.)6-DATE OF BIRTH, *October 26th, 1834*
(Month) (Day) (Year)7-AGE, *80* yrs. *9* mos. *17* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Lancaster, Maryland*10-NAME OF FATHER, *Hammond Shipley*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Dusau Fox*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Howard S. Andrews*(Address) *704 N. Carrollton Ave*15-
AUG 14 1915 HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 13th, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *January 1914*, to *August 13th 1915*, that I saw her alive on *August 13th 1915*, and that death occurred, on the date stated above, at *4:30 P. m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Arterio Sclerosis*

(Duration) yrs. mos. ds.

(Signed) *J. Howard S. Andrews* M. D.(Address) *704 N. Carrollton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Burton Park*DATE OF BURIAL, *Aug. 16, 1915*20-UNDERTAKER, *George J. Smith*ADDRESS, *808 W. Gay St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87461

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 W. Saratoga

ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Precilla Loring

(Residence in Baltimore: No. 2009 W. Saratoga

St.; 50 yrs., 7 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

About November

(Month)

?

(Day)

about
1849
(Year)

7-About

65 yrs.

9 mos.

?

ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

house-wife

9-BIRTHPLACE,

(State or Country),

Maryland.

10-NAME OF FATHER,

Willis Carlin

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Sarah Carlin Willis

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Mary E. Houck

(Address)

2009 W. Saratoga St.

15-

AUG 14 1915

Filed

191

Barial Permit cler

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August

13

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 18 1915, to August 13 1915,

that I saw her alive on August 12 1915,

and that death occurred, on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart.

(Duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY

(Secondary)

Ball stones

(Duration) ... yrs. ... mos. ... ds.

(Signed)

Chester Roland

M. D.

August 13 1915 (Address) 2532 Edmonson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cemetery

DATE OF BURIAL,

Aug. 16, 1915

20-UNDERTAKER

Stewart Shownen Co,

ADDRESS

108 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

87465

87465

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

Hebrew Hospital

ST.

WARD)

2 FULL NAME

Rose Berman

(Residence in Baltimore: No.

711 E Fayette St

St. 2

yrs. mos. ds.)

118
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

6 DATE OF BIRTH

Aug —, 1875

7 AGE

40

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE
(State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER
(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER
(State or country)

Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry

(Address)

1419 E Balto St

15 AUG 15 1915

HARRY O. ANDREWS,

Corial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 14, 1915

17 I HEREBY CERTIFY, That I attended deceased from

July 18, 1915, to Aug 14, 1915.

that I saw him alive on July 14, 1915.

and that death occurred, on the date stated above, at 9:00 p.m.

The CAUSE OF DEATH* was as follows:

Pancreatic tumor with general fatty necrosis.

(Duration) yrs. mos. 27 ds

Contributory Acute Cardiac Dilatation (SECONDARY)

(Duration) yrs. mos. 1 hour

(Signed) M. B. Lewis M. D.

Aug 14, 1915 (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 27 ds. In the State 2 yrs. mos. ds.

Where was disease contracted? 911 E Fayette St

If not at place of death? Former or usual residence 911 E Fayette St

19 PLACE OF BURIAL OR REMOVAL

Hebrew Mt Carmel 8/15, 1915

20 UNDERTAKER

Jack Lewis 1419 E Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1104 S. Kenwood Ave.* ST. *1* WARD)

2-FULL NAME

Adam Jagodinski

(Residence in Baltimore: No. *1104 S. Kenwood Ave.*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

6-DATE OF BIRTH.

Aug 13, 1915
(Month) (Day) (Year)

7-AGE.

— yrs. — mos. — ds.

If LESS than 1 day, 2 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer). *none*

9-BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Joseph Jagodinski

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Elagia Panowicz

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elagia Jagodinski*

(Address) *1104 S. Kenwood Ave.*

15-

AUG 15 1915

HARRY O. ANDERSON

Serial Permit No. 4107
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 13, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Ataxia Neuronium
7 months
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *D. W. Jones* M. D. (Coroner.)

Aug 14, 1915 (Address) *3116 E. Greenwell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Stanislaus Church

Aug 15, 1915

20-UNDERTAKER

ADDRESS

Stephen J. Fialkowski

1014 Kenwood Ave

C87468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C87468

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

325 S Dallas

ST. 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mammie Tete

(Residence in Baltimore: No.

325 S Dallas

St.; 1 yrs., 8 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Infant

6-DATE OF BIRTH,

January 10, 1914
(Month) (Day) (Year)

7-AGE,

1 yrs., 8 mos., 4 ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE,
(State or Country),

Balt

10-NAME OF FATHER,

Leppo Tete

11-BIRTHPLACE OF FATHER
(State or Country),

Alley

12-MAIDEN NAME OF MOTHER

Angeline Ricci

13-BIRTHPLACE OF MOTHER
(State or Country),

Alley

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Leppo Tete

(Address)...

325 S Dallas

15-

AUG 15 1915

HARRY O. ANDREWS,

Filed

191

Baltimore Health Dept. Alex. A.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 14, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 12, 1915, to May 17, 1915,

that I saw him alive on May 14, 1915,

and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

G. L. ... 1915 (Address) 6 S Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Vincent

DATE OF BURIAL,

Aug. 15, 1915

20-UNDERTAKER

Hendell Biffel & Son

ADDRESS

33 S. Bond St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.)

St.; 45 yrs., 7 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed.....

191.

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

JUNES 1915, to AUG 13 1915,

that I saw her alive on AUG 13 1915,

and that death occurred, on the date stated above, at 4:45 m.

The CAUSE OF DEATH* as follows:

Cerebral embolism

CONTRIBUTORY (Secondary)

(Signed)

Aug 14, 1915 (Address) 928 E. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Green Mount Cemetery Aug 16, 1915.

20-UNDERTAKER

ADDRESS

William Cook 502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

928 E. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

CERTIFICATE OF DEATH

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

101

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 7 mos. 19 ds. In the State yrs. 7 mos. 19 ds.

Where was disease contracted, if not at place of death? Nursery & Child Hospital

Former or usual residence Nursery & Child Hospital

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1918* *W. Balto* ST.; *20* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1711* *West Baltimore St.* St.; *62* yrs., *11* mos. *24* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Aug. *19*, *1853*
(Month) (Day) (Year)

7-AGE,

62 yrs., *11* mos., *24* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *At home*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Wm. Mullen*(Address) *1711 W. Baltimore St.*

15-

AUG 15 1915

HARRY O. ANDREWS,

Filed..... 191

Register.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug *13* *1915*
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *June 1* 191*5*, to *Aug 13* 191*5*, that I saw h *Erative* on *Aug 13* 191*5*, and that death occurred, on the date stated above, at *0 P.* m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Pulmonosis
(Duration)..... yrs..... mos. *2* ds.CONTRIBUTORY (Secondary) *Carcinoma of Esophagus**Edw. J. Gorman* (Signed) *Edward Gorman* M. D.
8/14, 191*5* (Address) *2027 W. Pratt St.*

State the DISEASE CAUSING DEATH, or, in Deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

Aug 16, 191*5*

20-UNDERTAKER

Henry W. Mearns & Son

ADDRESS

805 W. Calvert St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87472

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87472

CERTIFICATE OF DEATH

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *305 S. Robinson* ST. *1* WARD)

2-FULL NAME *Katherine Merryman*

(Residence in Baltimore: No. *305 S. Robinson* St. *Lifton* (Is.))

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE MARRIED WIDOWED OR DIVORCED *Married* (Write the word)

6-DATE OF BIRTH *June 22*, 1889 (Month) (Day) (Year)

7-AGE *26* yrs. *1* mos. *21* ds. or min. If LESS than 1 day, hrs., min.?

8-OCCUPATION (a) Trade, profession or particular kind of work *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Batte Nord*

10-NAME OF FATHER *Louis Krich*

11-BIRTHPLACE OF FATHER (State or country) *Germany*

12-MAIDEN NAME OF MOTHER *Katherine Meyer*

13-BIRTHPLACE OF MOTHER (State or country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *George H. Merryman*

(Address) *405 S. Robinson St.*

15-

AUG 15 1915

HARRY O. ANDREWS,

Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Aug. 13*, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 13*, 1915, to *1915*, that I saw her alive on *Aug 13*, 1915, and that death occurred, on the date stated above, at *7:4* m.

The CAUSE OF DEATH* was as follows:

Purpural Hemorrhage (Post Partum)

6 hrs. (Duration) yrs. mos. ds.

Contributory (SECONDARY) *Cardiac failure*

(Duration) yrs. mos. ds.

(Signed), *Chas. S. Meier* M. D.

Aug 14, 1915 (Address) *405 S. Robinson St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt Carmel

DATE OF BURIAL

Aug 15, 1915

20-UNDERTAKER

H. Sander & Sons

ADDRESS

1710 E. 10

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *28 S. Catharine* St.;

REGISTERED NO. C

WARD) *20*2-FULL NAME *Thelma, E. Nicholson*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *28 S. Catharine* St.;1 yrs., *2* mos. *8* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*6-DATE OF BIRTH, *June 5, 1914*

(Month)

(Day)

(Year)

7-AGE, *1* yrs., *2* mos., *8* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Edward H. Nicholson*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Sellie R. Harkins*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward H. Nicholson*(Address) *28 S. Catharine*

15-

AUG 15 1915

HARRY O. ANDREWS,

191-*191* Burial Permit *101-101* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 13, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 1, 1915* to *Aug 13, 1915*that I saw him alive on *Aug 13, 1915*and that death occurred, on the date stated above, at *7:00* m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis(Duration) yrs. mos. *13* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Walter A. Cot* M. D.E. 14, 1915. (Address) *541 Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park Cem*DATE OF BURIAL, *Aug 16, 1915*20-UNDERTAKER *Joe Saunders & Son*ADDRESS *217 S. Perry*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87474

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

87474

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2104 Fleet

ST. 1

WARD)

2-FULL NAME

Alice Laura Jubb

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM cut No. 18.)

(Residence in Baltimore: No. 2104 Fleet

St.; yrs. 7 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female White

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Nov

24, 1914

7-AGE

7 21

If LESS than

1 day, hrs.,

min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or country)

Baltimore

10-NAME OF FATHER

George Jubb

11-BIRTHPLACE OF FATHER

Baltimore

12-MAIDEN NAME OF MOTHER

Maggie Kitter

13-BIRTHPLACE OF MOTHER

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Jubb

(Address)

2104 Fleet St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 14, 1915

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1915, to Aug 14, 1915,

that I saw him alive on Aug 13, 1915,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

Contributory (SECONDARY)

Exhaustion

(Signed)

Chas. J. Keen M. D.

8/14/15, 191

[Address] 408 State St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Balto Cem

DATE OF BURIAL

Aug 15, 1915

20-UNDERTAKER

John Herwig

ADDRESS

2008 Orleans

AUG 15 1915

HARRY O. ANDREWS,

CERTIFIED BY REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87475

C87475

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1409 Light* ST. *24* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1409 Light St* St. *22* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*Divorced*

6-DATE OF BIRTH.

Sept 15, 1841
(Month) (Day) (Year)

7-AGE.

73 yrs. *10* mos. *29* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Farmer*
*Retired*9-BIRTHPLACE.
(State or Country),*Virginia*

10-NAME OF FATHER,

*Mary A Sabagrell*11-BIRTHPLACE OF FATHER
(State or Country),*Virginia*

12-MAIDEN NAME OF MOTHER

*Philip Parker*13-BIRTHPLACE OF MOTHER
(State or Country),*Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Albert Parker

(Address)

Brooklyn Md

15-

*AUG 15 1915**HARRY O. ANDREWS*

Filed.....

191.....

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 12, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Aug 11, 1915*, to *Aug 12, 1915*, that I saw him alive on *Aug 12, 1915*, and that death occurred, on the date stated above, at *12:00* m.

The CAUSE OF DEATH* was as follows:

Tumor in larynx, probably Papilloma

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)*Exhaustion from*
asphyxia (Duration).....yrs.....mos.....ds.(Signed).....*W. H. D.**8/13, 1915* (Address).....*1319 Light St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

Aug. 15 1915

20-UNDERTAKER

R. & M. J. Flynn

ADDRESS

1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1420 Clarkson*)

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Oliver F. Brosche(Residence in Baltimore: No. *1420 Clarkson*)St.; *29* yrs., *3* mo. *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

April 16, 1886
(Month) (Day) (Year)

7-AGE,

29 yrs., *3* mo., *27* ds.if LESS than 1 day.
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

Machinist
*Die Maker*9-BIRTHPLACE,
(State or Country),*Baltimore Md*10-NAME OF
FATHER,*William H. Brosche*11-BIRTHPLACE
OF FATHER
(State or Country),*Md.*12-MAIDEN NAME
OF MOTHER*Helmina C. Miller*13-BIRTHPLACE
OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Oliver F. Brosche

(Address)

2802 Harford Ave

15-

AUG 15 1915

Filed

191

HAROLD O. ANGLER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 13, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

*July 12, 1915, to Aug 13, 1915*that I saw him alive on *Aug 13, 1915*and that death occurred, on the date stated above, at *8:40 A.M.*

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration).....yrs.....mo.....ds.

CONTRIBUTORY
(Secondary)*Carcinoma of Bladder*
(Duration).....yrs.....mo.....ds.

(Signed)

B. J. Dwyer M. D.
Aug 15, 1915. (Address) 3016 Cross St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mo. ds. In the State yrs. mo. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cem.

DATE OF BURIAL,

Aug 16, 1915

20-UNDERTAKER

Eschelman & Son

ADDRESS

1039
W. Hanover St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *16 N Lakewood Av* ST. *6* WARD)

2-FULL NAME

Marion M. Patterson

(Residence in Baltimore: No. *16 N Lakewood Av* St. *6* yrs. *4* mos. *4* ds.)

REGISTERED No. C. *6*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widow

6-DATE OF BIRTH

May 11th 1850
(Month) (Day) (Year)

7-AGE

65 yrs. *3* mos. *3* ds. or min.?

If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

House work at home

9-BIRTHPLACE
(State or country)

Baltimore Md.

10-NAME OF FATHER

James E Collins

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Eveline Giese

13-BIRTHPLACE OF MOTHER
(State or country)

Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alice Hamen
16 N. Lakewood Av
(Address)

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

August 14 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 29th 1915*, to *Aug 14 1915*, that I saw her alive on *Aug 13 1915*, and that death occurred, on the date stated above, at *4 P. m.*

The CAUSE OF DEATH* was as follows:

Right Hemiplegia

Contributory (SECONDARY) *Hemiplegia* (Duration) yrs. *2* mos. ds.

(Signed) *R. P. Carman* M. D. *Aug 14 1915* [Address] *1701 N. Caroline St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Balto Am

DATE OF BURIAL

Aug 17 1915

20-UNDERTAKER

E + B Hauler

ADDRESS

115 E West St

AUG 15 1915

HARRY O. ANDREWS,

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1518 Poplar Grove ST. 16 WARD)

2 FULL NAME

William F. McCauley

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1518 Poplar Grove St. 64 yrs. 5 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH March 8, 1853
(Month) (Day) (Year)

7 AGE 62 yrs. 5 mos. 5 ds. IF LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Druggist
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Md

10 NAME OF FATHER John T. McCauley

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (State or country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. M. McCauley

(Address) 1518 Poplar Grove St

15 AUG 15 1915
Filed

HARRY O. ANDREWS
REGISTRAR
Serial Permit 6101

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 13, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1915, to Aug 13th, 1915, that I saw him alive on Aug 13th, 1915, and that death occurred, on the date stated above, at 5 P m. The CAUSE OF DEATH* was as follows:

Chronic Interst. Nephritis.

(Duration) yrs. 2 mos. ✓ ds.

Contributory (SECONDARY) ✓

(Duration) yrs. mos. ds.

(Signed) August Horn M. D.
Aug 14th 1915 (Address) 40 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Western DATE OF BURIAL Aug 16, 1915

20 UNDERTAKER Robt S. Little ADDRESS 31 N. Fremont

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1743 E. Alver* ST. *8* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1743 E. Alver* St.; — yrs. — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) *Married*

6-DATE OF BIRTH

*Oct 1**1878*

(Month)

(Day)

(Year)

7-AGE

36 yrs. *10* mos. *12* ds.

IF LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Aug 13**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 11 1915, to *Aug 13* 1915,that I saw him alive on *Aug 13* 1915,and that death occurred, on the date stated above, at *8:45* m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis(Duration) *3* yrs. *10* mos. *12* ds.

CONTRIBUTORY

(Secondary)

(Duration) *4* yrs. *10* mos. *12* ds.

(Signed)

Chas. B. Fisher

M. D.

Aug 13, 1915. (Address) *1830 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Funeral Home**Aug 16* 1915

20-UNDERTAKER

ADDRESS

*Robert Turner**1827 N. Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

105 C87480

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

1311 Madison Ave. St. 11

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

Annie Coover

(Residence in Baltimore: No.

1311 Madison Ave

St. 87 yrs. 10 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widowed

6 DATE OF BIRTH

Oct 10, 1827
(Month) (Day) (Year)

7 AGE

87 yrs. 10 mos. 3 ds. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE
(State or country)

Md

10 NAME OF FATHER

Greenbury Knapp

11 BIRTHPLACE OF FATHER
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Susanna Dertzboch

13 BIRTHPLACE OF MOTHER
(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Mollery

(Address)

1311 Madison Ave

15 AUG 15 1915

HARRY O. ANDERSON

Filed

191

Barial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 13, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug 5, 1915, to Aug 13, 1915.

that I saw her alive on Aug 13, 1915.

and that death occurred, on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH* was as follows:

Enteritis

Contributory
(SECONDARY)

Cardiac Failure
(Duration) yrs. 8 mos. 8 ds.

(Signed)

C. K. Jumper, M. D.
Aug 15, 1915 (Address) 841 N. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emetahug Md.

Aug 16, 1915

20 UNDERTAKER

ADDRESS

Reid J. Turner

1742 N. Brady

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(87481)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1520 N. Brunt street,

ST.

WARD

FULL NAME

Elizabeth Hunter,

(Residence in Baltimore: No. 1520 N. Brunt street,

St.; yrs., 5 mos. 5 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)
6-DATE OF BIRTH, March 8th, 1915. (Month) (Day) (Year)
7-AGE, 0 yrs., 5 mos., 5 ds. If LESS than 1 day, ...hrs. or ...min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.
10-NAME OF FATHER, William Hunter,
11-BIRTHPLACE OF FATHER (State or Country), Virginia,
12-MAIDEN NAME OF MOTHER, Agnes White,
12-BIRTHPLACE OF MOTHER (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Hunter, mother.

(Address) 1520 N. Brunt street.

15- AUG 15 1915 HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 13th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis.

CONTRIBUTORY Artificial feeding, (Secondary)

(Signed) J. Frederick Hampel, M. D. (Coroner.)

Aug. 15, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

MT. Auburn Aug. 15, 1915

20-UNDERTAKER, ADDRESS

James H. Dennis 1303 President St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *44 E Henrietta St.*)ST.; *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *44 E Henrietta St.*)St.; *6* yrs., *9* mos., *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, *Married*

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Nov 22, 1883.

(Month)

(Day)

(Year)

7-AGE,

61 yrs., *9* mos., *12* ds.

If LESS than 1 day,

...hrs. or...mins.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Bookkeeper*9-BIRTHPLACE,
(State or Country),*Balto*

10-NAME OF FATHER,

*James H. Orem*11-BIRTHPLACE OF FATHER
(State or Country),*Ind*

12-MAIDEN NAME OF MOTHER

*Mary E. Orem*13-BIRTHPLACE OF MOTHER
(State or Country),*Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Orem*(Address) *44 E Henrietta St*

15-

Filed *AUG 15 1915*

191

REGISTRAR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 14, 1915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 1 1913, to *Aug 14* 1915,that I saw him alive on *Aug 13* 1915,and that death occurred, on the date stated above, at *5 a* m.

The CAUSE OF DEATH* was as follows:

Embolism of Liver(Duration) *2* yrs., *10* mos., *10* ds.CONTRIBUTORY
(Secondary)(Duration) *10* yrs., *10* mos., *10* ds.(Signed) *H. H. Denny* M. D.*Aug 14*, 1915. (Address) *1425 Light St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

LOUDON PARK

DATE OF BURIAL

AUG 16 1915

20-UNDERTAKER

ARMSTRONG-DENNY CO.

ADDRESS

715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *803 Light*ST.; *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Eleanora J. Landon*(Residence in Baltimore: No. *803 Light St*St. *76* yrs., *4* mos. *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, *Married*,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *March 18, 1839*

(Month)

(Day)

(Year)

7-AGE, *76 4 27*

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country), *Baltimore Md*10-NAME OF FATHER, *Emory Glass*11-BIRTHPLACE OF FATHER
(State or Country), *Delaware*12-MAIDEN NAME OF MOTHER, *Rachael McCallister*13-BIRTHPLACE OF MOTHER
(State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Michael Landon*(Address) *803 Light St*

15-

Filed

AUG 15 1915

191

HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 14, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 8* 1915, to *May 14* 1915, that I saw her alive on *May 14* 1915, and that death occurred, on the date stated above, at *4 1/2* in.

The CAUSE OF DEATH* was as follows:

*Cerebral Apoplexy*CONTRIBUTORY
(Secondary)(Signed) *W. H. Hamner* M. D.*May 14, 1915* (Address) *835 Light St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

LOUDON PARK

DATE OF BURIAL,

*AUG 16 1915*20-UNDERTAKER
ARMSTRONG-DENNY CO.

ADDRESS

715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87485

HEALTH DEPARTMENT—CITY OF BALTIMORE.

C87485

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2007 Bunt*ST. *14* WARD) *120*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Henrietta Johnson(Residence in Baltimore: No. *2007 Bunt*St. *20* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widow*

6-DATE OF BIRTH

*Johnson**1844*

(Month)

(Day)

(Year)

7-AGE

71

yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

house

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

John Keown

11-BIRTHPLACE OF FATHER

(State or Country),

not known

12-MAIDEN NAME OF MOTHER

Henrietta Jones

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jack Johnson

(Address)

2007 Bunt St

15-

Filed *Aug 16* 1915

1915

Chas. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 1 1915, to *Aug 14* 1915,that I saw her alive on *Aug 14* 1915,and that death occurred, on the date stated above, at *8:30 p.m.*

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

no report(Signed) *Edward J. Short* M. D.*Aug 15* 1915 (Address) *1812 Dwing Hall Dr*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Carol Lee**Aug 15*

20-UNDERTAKER

ADDRESS

Sam'l B. Smith 1578 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

610 St Ann st

ST.;

9

WARD)

2-FULL NAME

Alma Griffin

(Residence in Baltimore: No.

610 St Ann st.

St.;

yrs.

7

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

SEPARATED,

OR DIVORCED.

(Write the word.)

Single

6-DATE OF BIRTH,

Jan 17

(Month) -

(Day) -

1915 (Year)

7-AGE,

7 yrs. 7 mos. - ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
- (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

William Griffin

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Edna Wilson

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

William Griffin

(Address)...

610 St Ann st

15-

Filed AUG. 16. 1915

Lester M. Lueder

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 14

(Month)

(Day)

1915 (Year)

I HEREBY CERTIFY, That I attended deceased from Aug. 12 1915, to Aug. 14 1915, that I saw her alive on Aug. 13 1915, and that death occurred, on the date stated above, at 9 9, m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Signed) J. E. Burnellack M. D.
Aug. 15, 1915. (Address) 1702 P. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Carmel Cemetery

DATE OF BURIAL,

Aug. 16, 1915

20-UNDERTAKER

George J. Ruth

ADDRESS

1735 Hayford ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *4* WARD)

2-FULL NAME *Frank Behelsky*

(Residence in Baltimore: No. *727 S. Ave. St.* St.; *1* yrs. *1* mos. *14* ds.)

REGISTERED NO. C. *104* *087487*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 12.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

July

(Month)

26

(Day)

1914

(Year)

7-AGE

1

Yrs.

1

Mos.

14

Ds.

Or

1

Min.

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Maryland

10-NAME OF FATHER

Peter Behelsky

11-BIRTHPLACE OF FATHER
(State or country)

Poland

12-MAIDEN NAME OF MOTHER

Frances Botz

13-BIRTHPLACE OF MOTHER
(State or country)

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Smith

(Address)

Johns Hopkins Hosp.

15-AUG 16 1915

Filed

191

W. M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August

(Month)

15

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

August 14, 1915 to *August 15, 1915*

that I saw him alive on *August 15, 1915*

and that death occurred, on the date stated above, at *6:50 am.*

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(Duration)

Yrs.

Mos.

Ds.

Contributory
(SECONDARY)

(Duration)

Yrs.

Mos.

Ds.

(Signed)

G. A. Patton

M. D.

August 15, 1915 [Address] *Johns Hopkins Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

Yrs.

Mos.

Ds.

In the

State

Yrs.

Mos.

Ds.

Where was disease contracted, If not at place of death?

Former or usual residence

727 Ann St

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Rosary Cemetery

August 16, 1915

20-UNDERTAKER

ADDRESS

Jacob Fialkowski 428 S. Bond

at

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Ind Gen Hospit.* ST.; *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1700 Webster* St.; *5* yrs., *11* mos. *16* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)

6-DATE OF BIRTH. *Aug.* *31.*, *1902*
(Month) (Day) (Year)

7-AGE. *5* yrs., *11* mos., *16* da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work *None.*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Balto. Md.*

10-NAME OF FATHER, *Benjamin Bell.*

11-BIRTHPLACE OF FATHER (State or Country), *Balto. Md.*

12-MAIDEN NAME OF MOTHER *Elsie M. Marsh.*

13-BIRTHPLACE OF MOTHER (State or Country), *Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elsie M. Bell (mother)*
(Address) *1700 Webster St.*

15-

Filed *Aug 16 1915* *Blumelacr*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August* *15th*, *1915*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 14th* *1915*, to *Aug 15th* *1915*, that I saw him alive on *Aug 15th* *1915*, and that death occurred, on the date stated above, at *7.30 A.M.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(Duration)..... yrs..... mos. *12* da.

CONTRIBUTORY..... (Secondary)

(Signed) *H. E. Shipley* M. D.
Aug. 15, 1915. (Address) *Ind. Gen. Hospit.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death..... yrs..... mos. *8 1/2* yrs. *5* mos. *11* da.

Where was disease contracted, if not at place of death? *at home, I suppose*

Former or usual residence *1700 Webster St.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

St. Carmel *Aug. 16, 1915.*

20-UNDERTAKER, ADDRESS

Edw. J. Manning *1460 Battery*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.—See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1931 Booth*)

2-FULL NAME

(Residence in Baltimore: No. *1931 Booth*)

ST. *20* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *11* mos. *25* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

6-DATE OF BIRTH,

Aug.

19th, *1914*

(Month)

(Day)

(Year)

7-AGE,

11 mos. *25* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Md.*

10-NAME OF FATHER, *Elbridge Booth*

11-BIRTHPLACE OF FATHER

(State or Country), *Md.*

12-MAIDEN NAME OF MOTHER *Rosa Williams*

13-BIRTHPLACE OF MOTHER

(State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elbridge Booth*

(Address) *1931 Booth*

15-

Filed *AUG 16 1915*

Blissclair

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 14, *1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

inquest find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Summer diarrhea
of gastro-enteritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Wm. M. Savage* M. D.

Aug. 14, 191*5* (Address) *1729 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAINING, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn

Aug. 16th

20-UNDERTAKER

A. Jones

ADDRESS

207 S. Street

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *731 E. 30 St.* ST. WARD)

2-FULL NAME

(Residence in Baltimore: No. *731 E. 30 St.* St.; yrs. *1* mos. *24* ds.)

REGISTERED No. C. *30*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female white

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

June 20, 1915
(Month) (Day) (Year)

7-AGE

If LESS than
1 day, hrs.,
yrs. *1* mos. *24* ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE
(State or country)

Balto. Md.

10-NAME OF FATHER

Chas F. Gekke

11-BIRTHPLACE OF FATHER
(State or country)

Balto. Md.

12-MAIDEN NAME OF MOTHER

Annie G. Loring

13-BIRTHPLACE OF MOTHER
(State or country)

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Mrs. Anna G. Gekke
(Informant)

(Address) *731 E. 30 St.*

15-

AUG 16 1915

Chas M. Suddar
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug. 14, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *Aug. 12, 1915*, to *Aug. 14, 1915*, that I saw her alive on *Aug. 14, 1915*, and that death occurred, on the date stated above, at *8:45 P.*

The CAUSE OF DEATH* was as follows:

Tubercular meningitis

(Duration) yrs. mos. *3* ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.
J. C. Bunnell
8-7-15, 1915. [Address] *12028 Monmouth*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery *Aug 16, 1915*

20-UNDEERTAKER

ADDRESS

Henry H. H. & Co. 1301 E. Eager St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1120 E 30th

ST.;

WARD)

REGISTERED NO. C

2-FULL NAME

George A. Beckle

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1120 E 30th

St.; 1 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH.

Dec. 10, 1914
(Month) (Day) (Year)

7-AGE.

8 yrs., 8 mos., 10 ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

mmr.

9-BIRTHPLACE,
(State or Country),

Balls MD.

10-NAME OF FATHER.

August Beckle

11-BIRTHPLACE OF FATHER
(State or Country),

Balls MD.

12-MAIDEN NAME OF MOTHER

Mary C. Eberle

13-BIRTHPLACE OF MOTHER
(State or Country),

Balls MD.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. August Beckle

(Address) 1120 E 30th St.

15-

AUG. 16, 1915.

191

Chas. M. McClure

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug. 14, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1915, to Aug. 14, 1915, that I saw him alive on Aug. 13, 1915, and that death occurred, on the date stated above, at 2³⁰ P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John J. Kuhn M. D.

Aug. 14, 1915 (Address) 540 E. 22nd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Redeemer Cemetery

DATE OF BURIAL.

Aug. 16, 1915

20-UNDERTAKER

Henry A. H. H. H.

ADDRESS

1301 E. 22nd St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087492

HEALTH DEPARTMENT—CITY OF BALTIMORE

087492

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 5-66 Walnut al. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Warfield

(Residence in Baltimore: No. 566 Walnut al. St. 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 71 4-COLOR OR RACE cd 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Single

6-DATE OF BIRTH 1870 (Month) (Day) (Year)

7-AGE 45 yrs. mos. ds. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Landman

9-BIRTHPLACE (State or country) Balladna

10-NAME OF FATHER Adam Warfield

11-BIRTHPLACE OF FATHER (State or country) Balladna

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Nash

(Address) 827 Vine St

15. AUG 16 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 8 13, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1, 1915, to Aug 13, 1915, that I saw him alive on Aug 13, 1915, and that death occurred, on the date stated above, at 6:40 m. The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) C. T. McLean M. D. Aug 13, 1915 (Address) 1303 N. Smith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Sam'l A. Chase & Son

1400 N. Chesapeake

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(87493

HEALTH DEPARTMENT—CITY OF BALTIMORE

(87493

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *2428 oak st*) ST. *12* WARD) REGISTERED No. C
2-FULL NAME *Barah J. Fox*
(Residence in Baltimore: No. *2428 oak st* St.: yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX <i>F</i>	4-COLOR OR RACE <i>negro</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>married</i>	16-DATE OF DEATH, <i>Aug 15, 1915</i> (Month) (Day) (Year)	17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>Inquiry</i> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <i>Inquest, au-</i> <i>topsy or inquiry</i> find that said deceased came to <i>her</i> death on the day stated above. The CAUSE OF DEATH* was as follows: <i>Death on Pulmonary</i> (Duration) yrs. mos. ds.
6-DATE OF BIRTH, <i>1866</i> (Month) (Day) (Year)	7-AGE, <i>47</i> yrs. mos. ds. If LESS than 1 day, hrs. or min.?	8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>House work</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>at home</i>	CONTRIBUTORY (Secondary) <i>None</i> (Signed) <i>Harry C. Flynn</i> (Coroner) <i>Aug 15, 1915</i> (Address) <i>3640 Roland Ave</i> State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
9-BIRTHPLACE, (State or Country), <i>va</i>	10-NAME OF FATHER, <i>Joseph Jackson</i>	11-BIRTHPLACE OF FATHER (State or Country), <i>va</i>	18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death?..... Former or usual residence.....	
12-MAIDEN NAME OF MOTHER, <i>Rose Booth</i>	13-BIRTHPLACE OF MOTHER (State or Country), <i>va</i>	14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Chas. H. Fox</i> (Address) <i>2428 oak st</i>	10-PLACE OF BURIAL OR REMOVAL, <i>Baily's Wharf Gloucester Co. Va.</i>	DATE OF BURIAL, <i>Aug. 14, 1915.</i>
15- <i>Chas. M. Sinclair</i>	20-UNDERTAKER, <i>Felix D. Pye</i>	REGISTRAR, <i>Chas. M. Sinclair</i>	ADDRESS, <i>102 G. Mullberry st.</i>	

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1—PLACE OF DEATH

CITY OF BALTIMORE, (NO. *419 N Carey*

2—FULL NAME

(Residence in Baltimore: No. *419 N Carey St*ST. *18*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *8* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3—SEX.

Female

4—COLOR OR RACE,

*White*5—SINGLE, *Single*~~MARRIED~~~~WIDOWED~~~~OR DIVORCED~~~~ILLEGITIMATE~~

6—DATE OF BIRTH,

Dec 20, 1914
(Month) (Day) (Year)

7—AGE,

8 yrs. *8* mos. *8* ds. *if LESS than 1 day, ...hrs. or ...min.?*

8—OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9—BIRTHPLACE, (State or Country),

Baltimore

10—NAME OF FATHER,

Frank C Perry

11—BIRTHPLACE OF FATHER (State or Country),

Baltimore

12—MAIDEN NAME OF MOTHER

Lillian M. Evans

13—BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14—THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank C Perry*(Address) *419 N Carey St*

15—

Aug 16, 1915

191

Chas. W. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16—DATE OF DEATH,

Aug 15, 1915
(Month) (Day) (Year)17— I HEREBY CERTIFY, That I attended deceased from *Aug 14* 1915, to *Aug 15* 1915, that I saw him alive on *Aug 15* 1915, and that death occurred, on the date stated above, at *9 1/2* m.

The CAUSE OF DEATH* was as follows:

Exhaustion
Cholera Infusion
Under professional care
24 hours (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Convulsions (Duration) yrs. mos. ds.(Signed) *C. H. Sayre* M. D.*Aug 15, 1915* (Address) *C. H. Sayre*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18—LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19—PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery *Aug 17, 1915*

20—UNDERTAKER

Wilbur W. Shriver *1018 E. Monument*

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87495 HEALTH DEPARTMENT—CITY OF BALTIMORE

15 87495

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 936 McDonough ST. 7 WARD)

REGISTERED NO. C

2-FULL NAME Baby Corcoran

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1936 McDonough St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, A. A.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, Aug. 10, 1915

(Month) (Day) (Year)

7-AGE, 4 yrs. 4 mos. 4 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER, Clarence Corcoran

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER, Elizabeth Farrow

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Corcoran

(Address) 1936 McDonough St.

15-

Filed 1915

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 15, 1915

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1915, to Aug. 15, 1915, that I saw her alive on Aug. 15, 1915, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Premature birth
6 mo. - 4 days

CONTRIBUTORS (Secondary)

(Duration) yrs. 4 mos. 4 ds.

(Signed) R. C. Gross

Aug. 15, 1915 (Address) 611 N. Carroll St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Aug. 16, 1915

20-UNDERTAKER, R. C. Gross

ADDRESS, 1405 McElderry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 16 1915

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *45* WARD)

2-FULL NAME *Baby Matthews*

(Residence in Baltimore: No. *413 Lewis St.* St.; yrs. mos. ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Black

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

May

(Month)

31

(Day)

1904

(Year)

7-AGE

1

yrs.

12

mos.

ds.

or min.?

if LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Maryland

10-NAME OF FATHER

James E. Rumpel

11-BIRTHPLACE OF FATHER
(State or country)

Ind

12-MAIDEN NAME OF MOTHER

Daisy Matthews

13-BIRTHPLACE OF MOTHER
(State or country)

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Smith

(Address)

Johns Hopkins Hosp

15-

Aug 16 1915

191

Chas. M. Sudder

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August

(Month)

14

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

August 14, 1915, to August 14, 1915,

that I saw her alive on *August 14, 1915,*

and that death occurred, on the date stated above, at *10:45 p.m.*

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(Duration)

yrs.

mos.

2

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

Grover F. Powers

M. D.

, 191. [Address]

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

1

yrs.

2

mos.

ds.

In the

State

yrs.

mos.

2

ds.

Where was disease contracted, if not at place of death?

unknown

Former or usual residence

413 Lewis St

19-PLACE OF BURIAL OR REMOVAL

Asbury Cem.

DATE OF BURIAL

Aug 16, 1915

20-UNDERTAKER

Mrs. J. G. Locke

ADDRESS

1302 Jefferson

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHEN COMPLETED WITH CARE AND ACCURACY THIS IS A PERMANENT RECORD

C87497

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

ST. 23 WARD)

Str.: yrs. 2 mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

Single

6-DATE OF BIRTH

6-7-1915
(Month) (Day) (Year)

7-AGE

— yrs. 2 mos. — ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Balto City

10-NAME OF FATHER

Samuel Jelly

11-BIRTHPLACE OF FATHER
(State or country)

Balto City

12-MAIDEN NAME OF MOTHER

Mary Hartman

13-BIRTHPLACE OF MOTHER
(State or country)

Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Jelly

(Address) 1016 Patapsco

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug. 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 9th, 1915, to 14th, 1915, that I saw him alive on Aug. 14th, 1915, and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:

Cholera Infantum

Contributory (SECONDARY)

(Duration) yrs. mos. 8 ds

Inanition

(Duration) yrs. mos. 3 ds

(Signed) Aug. 16th, 1915 (Address) 1701 Madison St. Gombel Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross A.C.C.

Aug 16, 1915

20-UNDERTAKER

ADDRESS

John J. Falsch 1318 Light

AUG 16 1915

Chas. M. Sinclair

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

REGISTERED NO. C.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and RH out No. 111.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

15-DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2622 E. Monument* ST.; *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2622 E. Monument* St.; *66* yrs., mos. *7* 1/2 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

*MARRIED**WIDOWED**OR DIVORCED**(Write the word.)**Married*

6-DATE OF BIRTH,

July 20, 1849
(Month) (Day) (Year)

7-AGE,

66 yrs. - *24* mos. *24* da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired 10 Years
Insurance

9-BIRTHPLACE,

(State or Country).

Balto., Co., Md.

10-NAME OF FATHER,

Joseph Ruppert

11-BIRTHPLACE OF FATHER,

(State or Country).

Germany.

12-MAIDEN NAME OF MOTHER

Catherine Weitzel

13-BIRTHPLACE OF MOTHER,

(State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Walter Ruppert

(Address)

2622 E. Monument

15-

*AUG. 16 1915**Chas. M. Fowler*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 14, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb 1915, to *Aug 14 1915*,that I saw him alive on *Aug 14 1915*,and that death occurred, on the date stated above, at *9:30 p.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate
(Clinical Diagnosis)(Duration) ... yrs. *6* mos. ... da.

CONTRIBUTORY

(Secondary)

(Duration) ... yrs. ... mos. ... da.

(Signed) *Charles F. Blake* M. D.*Aug 16, 1915* (Address) *20 E. Preston St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. ... mos. ... da. In the State yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Carmel Cemetery

DATE OF BURIAL,

Aug 17, 1915

20-UNDERTAKER

Gubler & Gubler

ADDRESS

1739 E. Eager St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87500

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

University Hospital

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Minnie Sherman

(Residence in Baltimore: No.

Ellicott City

St.: 9 yrs. mos. 7 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, Married
MARRIED, Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May

24, 1850

(Month)

(Day)

(Year)

7-AGE,

65?

yrs.

1

mos.

28

da.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

At Home

9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. C. W. Windsor

(Address)

903 S. Lennox St.

15-

Filed

1915

191

Chas. M. Snelgar

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug

(Month)

14

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from
Aug 13 1915, to Aug 14 1915,
that I saw her alive on Aug 14 1915,
and that death occurred, on the date stated above, at 9:20 A.M.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart
Disease

(Duration) about 2 mos. 7 da.

CONTRIBUTORY
(Secondary)Cardiac Decompensation
about 1 month

(Duration) about 1 mos. 7 da.

(Signed) Elmer Newcomer M. D.

Aug 14, 1915. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 1/2 da. In the State 9 yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

Ellicott City, Md.

19-PLACE OF BURIAL OR REMOVAL

Schwarze Cemetery

DATE OF BURIAL

Aug 16, 1915

ADDRESS 1739

20-UNDERTAKER

Jickler & Jickler

C. Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87501

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore; No.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(If not the wife)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF
FATHER

11-BIRTHPLACE
OF FATHER
(State or country)

12-MAIDEN NAME
OF MOTHER

13-BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

AUG 16 1915

REGISTRAR

Sarah Puryear

28

C87501

ST. 14 WARD)

(If death occurred in
a hospital or institution,
give its NAME instead of
street and number and
hill out No. 18.)

St. yrs. mos. ds.)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(At least three
months (Duration) yrs. 3 mos. 5 ds.)

Contributory
(SECONDARY)

(Signed) Edward Short M. D.
Aug 15, 1915 (Address) 1002 City St.

*State the DISEASE CAUSING DEATH, or, in cases of VIOLENT CAUSE,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wt. Auburn Cemetery

Aug. 16, 1915

20-UNDERTAKER

ADDRESS

Geo. H. Holland

577 Robert St.

WRITE PERMANENT, WITH ENDURING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1341 Andre St*)

2-FULL NAME *Bernard Sledz*

(Residence in Baltimore: No. *1341 Andre St*)

REGISTERED No. C

ST. *24* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str. yrs. *4* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

6-DATE OF BIRTH *Apr. 15, 1913* (Month) (Day) (Year)

7-AGE *4* yrs. *4* mos. — ds. or min. ? If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession, or particular kind of work *None* (b) General nature of industry, business, or establishment in which employed (or employer) *Infant.*

9-BIRTHPLACE (State or country) *Baltimore*

10-NAME OF FATHER *Peter Sledz*

11-BIRTHPLACE OF FATHER (State or country) *Russian Poland*

12-MAIDEN NAME OF MOTHER *Helen Krasniewski*

13-BIRTHPLACE OF MOTHER (State or country) *Russian Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Peter Sledz*

(Address) *1341 Andre St.*

15. Filed *Aug 16 1915* *Chas. M. Sinclair* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Aug 15, 1915* (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from *Aug 2, 1915* to *Aug 15, 1915*, that I saw him alive on *Aug 14, 1915*, and that death occurred, on the date stated above, at *12:30* m. The CAUSE OF DEATH* was as follows:

Marasmus

Contributory (SECONDARY) *Gastro Enteritis* (Duration) yrs. *4* mos. ds.

(Signed) *Joseph W. Miller* M. D. *Aug 5, 1915* (Address) *1612 E. Fort Ave.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Holy Cross* DATE OF BURIAL *Aug 15, 1915*

UNDERTAKER *William Tiesforn* ADDRESS *1618 Eastern Ave.*

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PERMANENT, WITH ENLARGING INK - THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *523 N. Stricker* ST. *19* WARD)

2-FULL NAME *Mary Elizabeth Emich*

(Residence in Baltimore: No. *523 N. Stricker* St. *19* yrs. *1* mos. *25* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *F* 4-COLOR OR RACE *Whi* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

6-DATE OF BIRTH *June 20, 1849* (Month) (Day) (Year)

7-AGE *66* yrs. *1* mos. *25* ds. If LESS than 1 day, ---hrs. or ---min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *None* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Balto. and*

10-NAME OF FATHER *Andrew E. Emich*

11-BIRTHPLACE OF FATHER (State or country) *Ind.*

12-MAIDEN NAME OF MOTHER *Annie M. Harris*

13-BIRTHPLACE OF MOTHER (State or country) *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Amanda J. Emich*

(Address) *523 N. Stricker*

15-*AUG 16 1915* Filed *Chas. M. Sinclair* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Aug 14, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Mar. 10*, 191*5*, to, *Aug 14*, 191*5*, that I saw her alive on *Aug 14*, 191*5*, and that death occurred, on the date stated above, at *8 P.* m. The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

Contributory (SECONDARY) *Carcinoma Liver + Stomach* (Duration) --- yrs. --- mos. --- ds. (Signed) *Dr. Caspari* M. D. *Aug 14, 1915* (Address) *1603 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death --- yrs. --- mos. --- ds. In the State --- yrs. --- mos. --- ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Western Cemetery* DATE OF BURIAL *Aug 17, 1915*

20-UNDERTAKER *George Smith* ADDRESS *1200 W. Fayette St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 247 S. Castle ST.; 2 WARD)2-FULL NAME John Francis Hagan(Residence in Baltimore: No. 247 S. Castle St.; 38 yrs., 6 mos., 24 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)6-DATE OF BIRTH. Jan. 20, 1876
(Month) (Day) (Year)7-AGE. 38 yrs., 6 mos., 24 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Laborer(b) General nature of industry, business, or establishment in which employed (or employer). Hard ware

9-BIRTHPLACE, (State or Country).

Balto. md.10-NAME OF FATHER. Michael Hagan11-BIRTHPLACE OF FATHER (State or Country). Ireland12-MAIDEN NAME OF MOTHER. Margaret Ann McKenna13-BIRTHPLACE OF MOTHER (State or Country). Balto. md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Margt. Hagan(Address). 247 S. Castle St.

15-

Blusnel Carr
Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH. Aug. 23, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug. 9 1915, to Aug. 13 1915, that I saw him alive on Aug. 13 1915, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Cerebral meningitis
(Duration) yrs. 1 mos. 1 ds.CONTRIBUTORY (Secondary) Occipital neuralgia(Signed) Geo. Heller M. D.
8/14, 1915. (Address) 1937 Gray St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral DATE OF BURIAL. Aug. 17, 191520-UNDERTAKER. John A. Moran ADDRESS Bank

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 16 1915

WRITE CAREFULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87505

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 2185 Canter St. 2 WARD)
2 FULL NAME James H. Hoey
(Residence in Baltimore: No. 2185 Canter St. 40 yrs. 0 mos. 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Aug, 1846
(Month) (Day) (Year)

7 AGE 69 yrs. 0 mos. 0 ds. or min. ? If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Fireman Balto
(b) General nature of industry, business, or establishment in which employed (or employer) Fire Dept

9 BIRTHPLACE (State or country) Ireland

10 NAME OF FATHER Michael Hoey

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Craig
(Address) 2185 S Balle

15. Aug 16 1915, 1915 Clos M. Sinclair
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 13, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1915, to Aug 13, 1915, that I saw him alive on Aug 12, 1915, and that death occurred, on the date stated above, at 6:30 p.m. The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

Contributory (SECONDARY) nephritis

(Signed) C. C. Rank M. D.

Aug 14, 1915 (Address) 2000 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL New Cathedral DATE OF BURIAL Aug 17 1915

20 UNDERTAKER John A Moran & Ann

Charles L. Metzger
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2172 W. Hollins

ST. 20 WARD)

REGISTERED NO. C. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Charles L. Metzger

(Residence in Baltimore: No. 2172 Hollins

St.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widowed

6-DATE OF BIRTH,

January 30, 1860
(Month) (Day) (Year)

7-AGE,

55 yrs., 6 mos., 15 ds.

If LESS than 1 day,

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Book Binder

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

August Metzger

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Elizabeth Metzger

(Address)

2172 Hollins St.

15-AUG 16 1915
Filed

Chas. W. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 14, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1, 1915, to Aug 13, 1915,

that I saw him alive on Aug 13, 1915,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) Unknown

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Walter A. ... M. D.

816, 1915. (Address) 53 T. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL,

Aug. 16, 1915.

20-UNDERTAKER

Geo. L. Schrab & Bro

ADDRESS

2101 E. Mt. Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 4 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) M. M. Savage, M. D.

(Coroner.)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. da. State, yrs. mos. da.

Where was disease contracted, if not at place of death?

former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8

C87503

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *9*)

2-FULL NAME *John Hopkins Hospital*

(Residence in Baltimore: No. *1418*)

John Hopkins Hospital
Welsh Jackson
1418 Madison St.

ST. *10*

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 11.)

St.; *1* yrs. *6* mos. *ds.*

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *June - 18th*, 19*14*
(Month) (Day) (Year)

7-AGE *1* yrs. *6* mos. *ds.* or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore*

PARENTS
10-NAME OF FATHER *Marve Jackson*
11-BIRTHPLACE OF FATHER (State or country) *Virginia*
12-MAIDEN NAME OF MOTHER *Estelle Jackson*
13-BIRTHPLACE OF MOTHER (State or country) *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

P. Gosgel
John Hopkins Hospital

15-*Blissman*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August 14th*, 19*15*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 24th*, 1915, to *Aug. 14th*, 1915, that I saw him alive on *Aug. 14th*, 1915, and that death occurred, on the date stated above, at *2:30* p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Contributory *pertussis & rickets*
(SECONDARY)

(Signed), *John Powers* M.D.
Aug. 14th, 1915 [Address] *John Hopkins Hospital*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *21* yrs. *6* mos. *ds.* In the State *1* yrs. *6* mos. *ds.*

Where was disease contracted, if not at place of death?

Former or usual residence *1418 Madison St.*

19-PLACE OF BURIAL OR REMOVAL *Laural Cemetery* DATE OF BURIAL *Aug 16*, 1915

20-UNDERTAKER *Robert A. Elliott* ADDRESS *506 East St.*

C87509 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 544 E. 22nd)

2-FULL NAME

Mrs. Catherine Hamilton

(Residence in Baltimore: No. 544 E. 22nd.)

REGISTERED NO. C.....

ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 60 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, WIDOW, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Aug. 13, 1895.
(Month) (Day) (Year)

7-AGE,

80 yrs. 0 mos. 0 da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

9-BIRTHPLACE,
(State or Country),10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 13, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

January 6 1915 to August 13 1915.

that I saw her alive on Aug. 13 1915.

and that death occurred, on the date stated above, at 10:40 p.m.

The CAUSE OF DEATH* was as follows:

Cancer on side of face.

(Clinical Diagnosis)

.....

..... (Duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Atheroma & old age

..... (Duration) yrs. mos. da.

(Signed) Reginald J. Torrey M. D.

Aug. 14, 1915. (Address) 414 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral

Aug. 17, 1915.

20-UNDERTAKER

ADDRESS

Edw. J. Manning 1938 E. Lafayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.; *15* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1811 Ashburton St.* St.; *2* yrs., *8* mos., *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Single*

6-DATE OF BIRTH,

Nov. 28, 1912
(Month) (Day) (Year)

7-AGE,

2 yrs., *8* mos., *18* ds.If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Record Mercy Hosp*(Address) *Calvert St.*

15-

Filed *Aug 16 1915*

1915

Chas. M. Sudaar

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 15, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Aug 13* 1915, to *Aug 15* 1915, that I saw him alive on *Aug 15* 1915, and that death occurred, on the date stated above, at *3:20 P.* m.

The CAUSE OF DEATH* was as follows:

Pneumophatic Abscess
abmt (Duration) *1* yrs., *10* mos., *15* ds.CONTRIBUTORY
(Secondary)*Sepsis* (Duration) *3* yrs., *3* mos., *3* ds.
(Signed) *Edward J. Smith* M. D.
Aug 15, 1915 (Address) *Mercy Hosp.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *2* yrs., *8* mos., *18* ds. In the *Life* State *2* yrs., *8* mos., *18* ds.Where was disease contracted, if not at place of death? *1811 Ashburton St.*Former or usual residence *1811 Ashburton St.*

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn Cemetery

DATE OF BURIAL,

Aug. 17, 1915

20-UNDERTAKER

Mrs. A. Rohde Fox

ADDRESS

730 Palmy

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87511

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87511

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *133 N. Broadway* ST. *2* WARD)

FULL NAME

Charles E. Young

(Residence in Baltimore: No. *133 N. Broadway* St.; yrs., *3* (mos. *2* ds.))

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, *Widow*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

May 15th, 1879
(Month) (Day) (Year)

7-AGE,

36 yrs., 2 mos., 30 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Driver

(b) General nature of industry, business, or establishment in which employed (or employer).

American Ice Co.

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Charles E. Young

11-BIRTHPLACE OF FATHER,

(State or Country),

Penn

12-MAIDEN NAME OF MOTHER,

Sarah St. Clair

13-BIRTHPLACE OF MOTHER,

(State or Country),

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

James Young (son)

(Address).....

133 N. Broadway

15-

Filed.....

1915

101.....

Chas M. Sinclair

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 14, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to *his* death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary pneumonia

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

Pulmonary tuberculosis

(Duration)..... yrs..... mos..... ds.

(Signed).....

David W. Jones M. D.
(Coroner)

Aug 14, 1915 (Address) *3116 Odum Rd.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery

Aug 17, 1915

20-UNDERTAKER

ADDRESS

H. E. Hughes

17 S Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 18 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-STATE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day, 4 hrs. or 15 min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE.
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8-14 1915, to 8-14 1915, that I saw her alive on 8-14 1915, and that death occurred, on the date stated above, at 4 P.m.

The CAUSE OF DEATH* was as follows:

Congenital Ataxia
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) P. L. Rush M. D.

8-14, 1915 (Address) University City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

COLLEGE OF P. & S.

AUG. 16 1915

20-UNDERTAKER

ADDRESS

Commissioner Health.

FOR ANATOMICAL PURPOSES.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *3110. Carrish* ST. *19* WARD)

2-FULL NAME *Rennie Joseph Ogle*

(If death occurred in a hospital or institution, give it; NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No. *3110. Carrish* St. yrs. *7* mos. *22* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
6-DATE OF BIRTH *Dec 23rd* 19*14*
(Month) (Day) (Year)
7-AGE *7* yrs. *22* mos. *22* ds. or *1* day, *—* hrs., *—* min.?
8-OCCUPATION
(a) Trade, profession or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country) *Maryland*

PARENTS

10-NAME OF FATHER *Rennie Thomas Ogle*
11-BIRTHPLACE OF FATHER (State or country) *Maryland*
12-MAIDEN NAME OF MOTHER *Clara Annie Booker*
13-BIRTHPLACE OF MOTHER (State or country) *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Clara Annie Booker*
(Address) *3110. Carrish St*

15-

Chas. N. Sinclair
191*5*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August 14* 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 14th* 191*5*, to, *Aug 15th* 191*5*, that I saw him alive on *August 14th* 191*5*, and that death occurred, on the date stated above, at *4:30 P. M.*
The CAUSE OF DEATH* was as follows:

Convulsions (Coma)

(Duration) *—* yrs. *—* mos. *1* ds.
Contributory (SECONDARY) *Eastro-Enteritis*
(Duration) *—* yrs. *—* mos. *1* ds.
(Signed) *Wm. J. G. Blane* M. D.
Aug 14 191*5* [Address] *1108. E. Baltimore*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *—* yrs. *—* mos. *—* ds. In the *—* yrs. *—* mos. *—* ds. State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Western Cemetery *Aug 16* 191*5*

20-UNDERTAKER ADDRESS *Harry H. Witzke* *1531 W. Lombard St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87514

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87514

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *819 Raborg* ST. *18* WARD) REGISTERED No. C
2-FULL NAME *May Howard*
(Residence in Baltimore: No. *819 Raborg*)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
St.; yrs. *lifetime* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Col* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married*
(Write the word.)
6-DATE OF BIRTH, *Apr. 9, 1871*
(Month) (Day) (Year)

7-AGE, *44 yrs. 4 mos. 4 ds.* If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Morrill*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward Howard*
(Address) *819 Raborg St*

15- *AUG 16 1915* 101 *Chas. M. Sinclair*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 13, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*
(Inquest, au-
topsy or inquiry)
and that said deceased came to death *her*
on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) *Chr. Nephritis* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Chr. Nephritis*

(Signed) *J. J. Jeffers* M. D.

(Address) *4434 Carrollton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mount Auburn Inty Aug 16, 1915

20-UNDERTAKER *Leon Hall* ADDRESS *1741 Dunc*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1721 Taylor St.; 20 yrs., 1 mos. 1 ds.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug. 14, 1945
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
Aug. 11, 1915, to Aug. 14 1915,
that I saw her alive on Aug. 14 1915,
and that death occurred, on the date stated above, at 4:35 p.m.

The CAUSE OF DEATH* was as follows: *

..... (Duration)..... yrs... 2... mos... .. ds.
CONTRIBUTORY Cardiac asthma.....
(Secondary)

..... (Duration) yrs..... mo..... da.
(Signed) M. D.
Aug 25 1914 (Address) 611 N. Benton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence

[illegible]

20. UNDERTAKER *W. H. H. H.* ADDRESS *512 1/2 St. - 7*

George A. Holland 3111 Wood St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N. Maderia ST.; 7 WARD)2-FULL NAME Paul C. Dunn(Residence in Baltimore: No. 508 N. Maderia St.; 5 yrs., 29 mos., 29 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Single

6-DATE OF BIRTH,

July
(Month)17
(Day)1915
(Year)

7-AGE,

5 yrs., 29 mos., 29 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

None9-BIRTHPLACE,
(State or Country),Balto, Md

PARENTS.

10-NAME OF FATHER,

Paul Dunn

11-BIRTHPLACE OF FATHER

(State or Country),

Balto

12-MAIDEN NAME OF MOTHER

Barbara Petri

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Dunn(Address) 508 N. Maderia

15-

AUG 16 19151915Chas M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Augt. 16
(Month)

(Day)

1915
(Year)

17 I HEREBY CERTIFY, That I attended deceased from Augt 15 1915, to Augt 16 1915, that I saw him alive on Augt 15 1915, and that death occurred, on the date stated above, at 3:45 m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Adolph C. Crispien, M. D.
Augt. 16, 1915 (Address) 7701-3 Orleans St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 5 mos. 29 ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? 508 N Maderia St

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Holy RedeemerAug 17, 1915

20-UNDERTAKER

ADDRESS

William Cook502 E Northave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087517 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 087517

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 889 W. Lafayette ST. 18 WARD)
FULL NAME George A. Huntington
(Residence in Baltimore: No. 889 W. Lafayette St. St.; yrs. 40 mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE. white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. married
6-DATE OF BIRTH. March 17, 1843 (Month) (Day) (Year)
7-AGE. 72 yrs. 4 mos. da. If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. Retired. (b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE. (State or Country). Virginia
PARENTS.
10-NAME OF FATHER. Unknown
11-BIRTHPLACE OF FATHER (State or Country). Va.
12-MAIDEN NAME OF MOTHER. Unknown
13-BIRTHPLACE OF MOTHER (State or Country). Unknown
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Clara Huntington (Address) 889 W. Lafayette St.
15- Filed AUG 16 1915 191. Char. M. Lindner Registrar.
CORONER'S CERTIFICATE OF DEATH.
16-DATE OF DEATH August 13th 1915 (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
(Duration) ... yrs. ... mos. ... da.
CONTRIBUTORY (Secondary) Heat exhaustion
(Signed) M. S. Savary M. D. (Coroner.)
Aug 14 1915. (Address) 179 W. Lafayette St.
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...
19-PLACE OF BURIAL OR REMOVAL. Western Cemetery DATE OF BURIAL. Aug 16, 1915
20-UNDERTAKER. William Cook ADDRESS 502 E. State

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *131 N. Montgomery* ST. *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *131 N. Montgomery*St. *50* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)6-DATE OF BIRTH, *Aug. 28th, 1829*
(Month) (Day) (Year)7-AGE, *85* yrs. *11* mos. *18* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *House Duties*
(b) General nature of industry, business, or establishment in which employed (or employer), *At Home*9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *Gen. Lux*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Stroebel*(Address) *802 Ridgely St*15-*Almsclarr*

161 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 14th, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 2nd 1915*, to *Aug 14th 1915*, that I saw her alive on *Aug 14th 1915*, and that death occurred, on the date stated above, at *2:30 p.m.*

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis(Duration) *—* yrs. *04* mos. *10* ds.

CONTRIBUTORY (Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.(Signed) *Edwin Michan* M. D.*Aug 16th 1915* (Address) *1711 N. Fayette St*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cremation London 10th Aug. 17th 1915

20-UNDERTAKER

ADDRESS

Mrs. John H. Teufel 801 N. Fayette St. Buried at Mt. Carmel.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

087519

HEALTH DEPARTMENT—CITY OF BALTIMORE

087519

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

BALTIMORE: (No. 431 S. Paca

ST. 22 WARD)

REGISTERED NO. C

FULL NAME

Dominick Brunkas

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 431 S. Paca St.

St.: yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 27, 1915 (Month) (Day) (Year)

7-AGE, 1 yrs. 19 mos. 19 da. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). No one

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, Dominick Brunkas

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Ann Ignatius

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dominick Brunkas

(Address) 431 S. Paca Street

15- AUG 16 1915 101 Chas M. Sinclair Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 15, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY That I attended deceased from Aug 12 1915 to Aug 15 1915 that I saw him alive on Aug 15 - 1915 and that death occurred, on the date stated above, at 2:30 A. m. The CAUSE OF DEATH* was as follows:

Cholera infantum (Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. da.

(Signed) M. C. Fullen M. D. Aug 16 1915 (Address) 682 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislawas DATE OF BURIAL, Aug 17, 1915.

20-UNDERTAKER, John Geblianus ADDRESS, 500 S. Paca

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1415 John* ST. *W* WARD)

2-FULL NAME

Ella Lee Wellmore Wm Rose(Residence in Baltimore: No. *1415 John St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *10* yrs. *10* mos. *10* ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Widowed

6-DATE OF BIRTH,

Sept. 20, 1850

(Month)

(Day)

(Year)

7-AGE,

64 yrs. *10* mos. *27* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Baltimore, Maryland*

10-NAME OF FATHER,

*Edward Wellmore*11-BIRTHPLACE OF FATHER
(State or Country),*Montgomery Co., Md.*

12-MAIDEN NAME OF MOTHER

*Lucretia Harwood*13-BIRTHPLACE OF MOTHER
(State or Country),*West River, Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Grace L. Wellmore*(Address) *1415 John St.*

15-

AUG 16 1915

HARRY O. ANDREWS,

Filed *1915* *1415 John St.*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 16, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

March 23, 1915 to *Aug 16, 1915*that I saw her alive on *August 15, 1915*and that death occurred, on the date stated above, at *9:40* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
(Duration) *7* yrs. *6* mos. *10* ds.CONTRIBUTORY
(Secondary)(Duration) *3* yrs. *3* mos. *10* ds.(Signed) *Edwin K. Ballou* M. D.*Aug 16, 1915* (Address) *1622 Mt. Royal*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Ridge Spring S.C.

DATE OF BURIAL

Aug 17, 1915

20-UNDERTAKER

Henry H. Jenkins & Sons, Col. Richard St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *813 N. Calvert* ST. *11* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *813 N. Calvert* St. *50* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH,

Sept 8, 1844
(Month) (Day) (Year)

7-AGE,

70 yrs. 11 mos. 6 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Deputy*(b) General nature of industry, business, or establishment in which employed (or employer) *Baltimore City Jail*

9-BIRTHPLACE, (State or Country),

Ireland

10-NAME OF FATHER,

Bernard Delaney

11-BIRTHPLACE OF FATHER

(State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER

Mary McElroy

13-BIRTHPLACE OF MOTHER

(State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Molly M. Delaney*(Address) *813 N. Calvert St.*

15-

AUG 16 1915

Filed

191

HARRY O. ANDREWS
Berial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

8, 14, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 2nd* 1915 to *Aug 14th* 1915, that I saw him alive on *Aug 14th* 1915, and that death occurred, on the date stated above, at *5:30 a.m.*

The CAUSE OF DEATH* was as follows:

Senile Hemiplegia - Apoplexy - Paralysis of right side.
(Duration).....yrs.....mos. *13* ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Edw. W. Anderson* M. D.*Aug 15, 1915* (Address) *208 Avenue*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

Aug. 17, 1915.

20-UNDERTAKER

Henry W. Mansel

ADDRESS

108 N. Calvert St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 N. Chester

ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Anna P. Wurtz

(Residence in Baltimore: No. 1217 N. Chester

St.: 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH,

Dec 27, 1876, 1
(Month) (Day) (Year)

7-AGE,

38 yrs., 7 mos., 18 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

house work

9-BIRTHPLACE, (State or Country).

Prussia

10-NAME OF FATHER,

Wm. Biermann

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Louise Brandt

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John R. Wurtz

(Address) 1217 N. Chester St.

15-

AUG 16 1915 HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 15, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 4 1915, to Aug 15 1915,

that I saw her alive on Aug 14 1915,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs., 4 mos., 18 ds.

CONTRIBUTORY (Secondary)

(Duration) 4 yrs., 4 mos., 18 ds.

(Signed) J. H. S. Frimby, M. D.

8/15, 1915. (Address) 1223 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Philadelphia Pa

DATE OF BURIAL,

Aug 17 1915.

20-UNDERTAKER

John Herwig & Co

ADDRESS

2018 Adams

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 W. Franklin ST.: 20 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1801 W. Franklin ST.: 43 yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)
Married

6-DATE OF BIRTH,

Oct 23, 1846
(Month) (Day) (Year)

7-AGE,

68 yrs., 9 mos., 23 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).School Teacher9-BIRTHPLACE,
(State or Country),Germany

10-NAME OF FATHER,

Ludwig Schrock11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Not known13-BIRTHPLACE OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mathie Schrock(Address) 1801 W. Franklin St.

15-

Filed AUG 16 1915 191... HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 10, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 12, 1913, to Aug. 15, 1915,that I saw him alive on Aug. 15, 1915,and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis(Duration) yrs., mos., ds.CONTRIBUTORY... Right's disease(Secondary) (Duration) yrs., mos., ds.(Signed) J. J. P. P. M. D.Aug. 16, 1915. (Address) 11001 Annapolis

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Lorraine Cemetery

DATE OF BURIAL,

Aug 18, 1915

20-UNDERTAKER

John Herwig & Co

ADDRESS

2008 Calver

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 23 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. 35 yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Keeley Jr.

(Address) 28 E. Heath St.

15-AUG 16 1915

Filed. 191. HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

Aug 10 1915, to Aug 15 1915, that I saw him alive on Aug 15 1915, and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration), yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Stomach

(Duration), yrs. mos. ds.

(Signed) Jas A. Osbourne M. D.

Aug. 16/1915 (Address) 107 E. Mt. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Holy Cross Cemetery Aug. 18, 1915.

20-UNDERTAKER ADDRESS

W. M. Flynn 1422 Light St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 Mount

ST. 16

WARD)

REGISTERED NO. C

2-FULL NAME

Mary Magdalene Robinson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 809 Vincent St

St.; 6 yrs., 3 mos., 12 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female Colored

4-COLOR OR RACE,

5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May 2nd, 1909
(Month) (Day) (Year)

7-AGE,

6 yrs., 3 mos., 12 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, none

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Harry Owen Robinson

11-BIRTHPLACE OF FATHER
(State or Country),

Prince George's Co. Md.

12-MAIDEN NAME OF MOTHER

Elsa Williams

13-BIRTHPLACE OF MOTHER
(State or Country),

Prince George's Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harry Robinson

(Address)

809 Vincent St.

15-

AUG 16 1915

HARRY O. ANDREWS,

Marital Permit Clerk

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 14th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 28th 1915, to Aug 14th 1915,that I saw her alive on Aug 14th 1915,

and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope

CONTRIBUTORY (Secondary) Cir. Bro. Spinal Meningitis

(Duration) yrs. mos. 3 ds.

(Duration) yrs. mos. 1 ds.

(Signed) Drs. Shorley & Lee M. D.

Aug. 14, 1915. (Address) 1127 Mount St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 17 ds. State 6 yrs. 3 mos. 12 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 809 Vincent St.

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

Aug 17, 1915

20-UNDERTAKER

Walter Brown

ADDRESS

306 N. Mount St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Scott St & Ohio Ave. 4*)

FULL NAME *Thomas C. Lynch*

(Residence in Baltimore: No. *411 N. Green*)

REGISTERED No. C.....

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

married

6-DATE OF BIRTH,

June 12, 1878
(Month) (Day) (Year)

7-AGE,

37 yrs. *2* mos. *3* da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

carpenter
carpenter

9-BIRTHPLACE, (State or Country),

Balto. Md

10-NAME OF FATHER,

Thomas Lynch

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary E. Sellers

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anna Lynch*

(Address) *411 N. Green St.*

15-

AUG 17 1915

191

Chas. M. Sullivan

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, au-

Inquest find that said deceased came to *his* death

topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Run over by R.R. train
accident

(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

Shock of Hemorrhage

(Duration) ... yrs. ... mos. ... da.

(Signed) *Samuel M. D.*

Aug 16, 1915 (Address) *2302 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death... yrs. ... mos. ... da. State... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Our Cathedral Church *Aug 17, 1915*

20-UNDERTAKER

ADDRESS

John J. Cowan *Low 901 Hallway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2867 W. Lafayette Ave. St.; 16 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2867 W. Lafayette Ave. St.; 77 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

November 10, 1838
(Month) (Day) (Year)

7-AGE,

77 yrs., mos., ds.

If LESS than 1 day,

0 hrs. or 0 min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer), House9-BIRTHPLACE, (State or Country), Cecil Co. Md.10-NAME OF FATHER, William Cather11-BIRTHPLACE OF FATHER (State or Country), Cecil Co. Md.12-MAIDEN NAME OF MOTHER, Sarah Jacobs13-BIRTHPLACE OF MOTHER (State or Country), Cecil Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellie Bran(Address) 2867 W. Lafayette Ave.

15-

AUG 17 1915

1915

Chas. M. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 15, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY. That I attended deceased from May 30 1915, to Aug 15 1915, that I saw him alive on Aug 14 1915, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Mucosar Membranosa!
Carcinoma of Larynx
Jaw (very max)
(Duration) 3 yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Signed) Marion W. Shook M. D.
Aug 16, 1915 (Address) 806 N. Tilton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cem

DATE OF BURIAL,

Aug 17, 1915

20-UNDERTAKER

Robert. Brooks Son & Co. Calhoun & Hollins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

29

087528

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 L. Walsh ST. 14 WARD)

2-FULL NAME

Patrick Fitzhenry

(Residence in Baltimore: No. 1801 L. Walsh St.; 5 yrs. mos. ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Mar

15, 1892

(Month)

(Day)

(Year)

7-AGE

33

4

1

ds.

or

min.

If LESS than

1 day, hrs.,

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Cigar maker

9-BIRTHPLACE

(State or country)

Ireland

10-NAME OF FATHER

Nicholas Fitzhenry

11-BIRTHPLACE OF FATHER

(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Mary Doyle

13-BIRTHPLACE OF MOTHER

(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. William Frey MD

(Address)

1928 Penna. Ave

15

Filed

17

191

Chas M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug

16

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 1, 1915, to, Aug 16, 1915,

that I saw him alive on Aug 16, 1915,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute intercurculosis of lungs

(Duration)

1

6

mos

ds.

Contributory (SECONDARY)

Cardiac Asthenia

(Duration)

3

mos

ds.

(Signed) W. William Frey M. D.

Aug 15, 1915. [Address] 1928 Penna. Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

Cathedral

PLACE OF BURIAL OR REMOVAL St. Peter's

DATE OF BURIAL

Aug 19, 1915

19-UNDERTAKER

William Cook

ADDRESS

502 E. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87529

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *609 Wyanoke Ave* ST.; *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *609 Wyanoke Ave* St.; *20* yrs., *12* mos., *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE

6-DATE OF BIRTH

7-AGE

IF LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

MAY 28 1915, to *Aug 16* 1915,that I saw her alive on *Aug 15* 1915,and that death occurred, on the date stated above, at *3:15* m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

CONTRIBUTORY (Secondary)

(Signed)

Aug 16 1915 (Address) *928 E North Ave*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs., *7* mos., *4* ds. In the State *1* yrs., *1* mos., *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87530

C87530

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

University Md. Hosp 21
Edward C. Bragg
1268 James St.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>male</i>	4-COLOR OR RACE, <i>white</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>Single</i> (Write the word)
6-DATE OF BIRTH, <i>Aug 27, 1901</i> (Month) (Day) (Year)		
7-AGE, <i>13 yrs. 11 mos. 20 da.</i>		If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <i>none</i> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), <i>Balto.</i>		
PARENTS.	10-NAME OF FATHER, <i>William C. Bragg</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Balto.</i>	
	12-MAIDEN NAME OF MOTHER, <i>Hettie Peurman</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Balto.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

W. C. Bragg
1268 James St.

15-

Filed.....

191

Cha M. Sinclair
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-

inquiry find that said deceased came to *his* death
topsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns of body (accidental)
Shock
(Duration)..... yrs..... mos..... da.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... da.

(Signed)..... M. D.

Aug 17, 1915 (Address) *1137 Carrington Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... da. In the *13* yrs..... mos..... da.

Where was disease contracted, if not at place of death?.....

1268 James St.

Former or usual residence *1268 James St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill Cem

Aug 18, 1915

20-UNDERTAKER

ADDRESS

for furnishings, etc 217 S. Pac.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOTED BY THE HEALTH DEPARTMENT WITH GRATEFULNESS FOR THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH
2 OF BALTIMORE: (No. *Johns Hopkins Hospital* St. *7* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
3-FULL NAME *Elmer Cook*
(Residence in Baltimore: No. *1036 W. Durham* St.; *2* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *Colored* 5-SINGLE MARRIED *Single* WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH *August 31* 1913 (Month) (Day) (Year)
7-AGE *2* yrs. mos. ds. or min. If LESS than 1 day, hrs.
8-OCCUPATION (a) Trade, profession or particular kind of work *None* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Baltimore

PARENTS

10-NAME OF FATHER

John Cook

11-BIRTHPLACE OF FATHER (State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Viola Coleston

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. Roszel*

(Address) *Johns Hopkins Hospital*

15-

Filed

AUG 17 1915

Chas. M. Lindsay

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 14 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *July 17* 1915, in *August 14* 1915, that I saw him alive on *August 31* 1915, and that death occurred, on the date stated above, at *9 P.M.*

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

Contributory (SECONDARY)

acute laryngitis

(Signed)

Grove F. Powers

Aug. 14 1915

[Address]

Johns Hopkins Hospital

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death yrs. mos. *28* ds. In the State yrs. mos. ds. *2*

Where was disease contracted, if not at place of death?

Former or usual residence

1036 W. Durham

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laurel cemetery aug 17

1915

20-UNDERTAKER

ADDRESS

Milton Davis 1608 McElderry St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. 2

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Baby Cano Mainson(Residence in Baltimore: No. *1623 Thames St.*St. *1 3/4 hrs.* yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)

6-DATE OF BIRTH.

Aug. 15, 1915
(Month) (Day) (Year)

7-AGE.

If LESS than 1 day.

1. hrs. 45 min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country).*Maryland*

10-NAME OF FATHER.

*Mmanuel Mainson*11-BIRTHPLACE OF FATHER.
(State or Country).*Spain*

12-MAIDEN NAME OF MOTHER.

*Adela Cano.*13-BIRTHPLACE OF MOTHER.
(State or Country).*Spain*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *L. L. Bousford*(Address) *JH Hospital*

15-

Filed *AUG 17 1915* *Bliss*

JOHNS HOPKINS HOSPITAL

16-DATE OF DEATH.

August 15, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 15, 1915* to *Aug 15, 1915*, that I saw h alive on *Aug 15, 1915*, and that death occurred, on the date stated above, at *2 15 a m.*

The CAUSE OF DEATH* was as follows:

Congenital Lues(Duration) *7 yrs. mos. da.*CONTRIBUTORY
(Secondary)(Duration) *7 yrs. mos. da.*(Signed) *Wm. L. Miller* M. D.*Aug 15, 1915* (Address) *Johns Hopkins Hosp.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

AUG 17 1915

20-UNDERTAKER

Coroner's Health

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FOR ANATOMICAL PURPOSES

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *806 S. Bond*)

2-FULL NAME *Andrew Rachuba*

(Residence in Baltimore: No. *806 S. Bond*)

ST. *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *2* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Not Known, 1839
(Month) (Day) (Year)

7-AGE,

76 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Day Laborer

9-BIRTHPLACE.

(State or Country),

Russia Poland

10-NAME OF FATHER,

Jacob Rachuba

11-BIRTHPLACE OF FATHER

(State or Country),

Russia Poland

12-MAIDEN NAME OF MOTHER

Frances Maslowska

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rachuba*

(Address) *806 S. Bond St*

15-

Filed *17* 1915

191

Chas. M. Sinclair

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 16, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, au-

Inquest and that said deceased came to *his* death topsy or inquiry on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

Semility

(Signed) *Sam'l W. H. M. D.*

(Coroner) *Aug. 17, 1915* (Address) *2302 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death. yrs. mos. da. State. yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

Aug. 18, 1915

20-UNDERTAKER

M. F. Sadowski

ADDRESS

705 S. Green St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87535

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Clara Porter(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.;

yrs.,

mos.

20 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June
(Month)*12th*
(Day)*1915*
(Year)

7-AGE,

2 yrs. *3* mos. *3* da.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

Filed

191

Chas M. Swelair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug.
(Month)*15th*
(Day)*1915*
(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1st 1915, to *Aug 15* 1915,that I saw her alive on *Aug 15th* 1915,and that death occurred, on the date stated above, at *3:45 P.M.*

The CAUSE OF DEATH* was as follows:

*Malnutrition and**Malassimilation*(Duration) *1* yrs. *1* mos. *1* da.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. *1* mos. *1* da.(Signed) *J. P. Sullivan*

M. D.

191... (Address) *615 Columbia St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *20* da. In the State yrs. *2* mos. *3* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral**Aug 17, 1915*

20-UNDERTAKER

ADDRESS

M. Fahney & Sons 606 Lafayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *808 Mulberry St.* 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Hilda E. Melcher.*(Residence in Baltimore: No. *808 W. Mulberry St.* yrs. *10* mos. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *Oct 19th, 1914*

(Month)

(Day)

(Year)

7-AGE, yrs. *10* mos. *7* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Grover Melcher*11-BIRTHPLACE OF FATHER, (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER, *Edna Polley*13-BIRTHPLACE OF MOTHER, (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edna Melcher*(Address) *808 Mulberry St.*

15-

Filed. *AUG 17 1915*

191

Chas M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 16, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 6, 1915*, to *Aug 16, 1915*, that I saw her alive on *Aug 16, 1915*, and that death occurred, on the date stated above, at *11 P. m.*

The CAUSE OF DEATH* was as follows:

Septic Enteritis(Duration) yrs. mos. *19* ds.CONTRIBUTORY (Secondary) *Malnutrition*

(Duration) yrs. mos. ds.

(Signed) *Shiphord Dr. M. D.*(Address) *1227 Calverton St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *3* mos. ds. In the State yrs. *10* mos. *7* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park*DATE OF BURIAL, *Aug 18, 1915*20-UNDERTAKER, *M. Fahney & Sons*ADDRESS, *606 Lafayette St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—19-12—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *820 Harford Ave* ST.; *10* WARD)

2-FULL NAME

(Residence in Baltimore: No. *820 Harford Ave*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *45* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

not known, *1*.....
(Month) (Day) (Year)

7-AGE,

about 68

If LESS than 1 day,

.....yrs.mos.da.hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Retired

Engineer

9-BIRTHPLACE, (State or Country),

Ireland

10-NAME OF FATHER,

Thomas Curley

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER (State or Country),

not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Budget Curley*

(Address) *820 Harford Ave*

15-

Charles M. Lucian AUG 17 1915.
Filed

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 23, 1915*, to *Aug 16, 1915*,
that I saw him alive on *Aug 15, 1915*,
and that death occurred, on the date stated above, at *8 A.M.*

The CAUSE OF DEATH* was as follows:

Chronic Bright's disease

(Duration).....yrs. *6*.....mos.da.

CONTRIBUTORY (Secondary)

Myocarditis

(Duration).....yrs. *7*.....mos.da.

(Signed).....*Bernard Weiss* M. D.

8/16, 1915. (Address) *911 S. Biddle St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.da. In the Stateyrs.mos.da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Cross Cemetery

DATE OF BURIAL.

Aug 18, 1915

20-UNDERTAKER

Henry Horne Lory

ADDRESS

1301 E. Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hahnemann Tril Hospital*
 CITY OF BALTIMORE: (No. *1122 N. Mount* ST.; *8* WARD)
 2-FULL NAME *Elizabeth Burnett (Burker)*
 (Residence in Baltimore: No. *1729 E Federal* St.; *Lyons* mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*
 6-DATE OF BIRTH, *Nov 13th, 1852*
 (Month) (Day) (Year)
 7-AGE, *58* yrs. *9* mos. *3* da. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *none*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*

PARENTS.

10-NAME OF FATHER, *William Laughery*
 11-BIRTHPLACE OF FATHER (State or Country), *Germany*
 12-MAIDEN NAME OF MOTHER, *Mathilda Koch*
 13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. Ferdinand Pense*
 (Address) *1729 E Federal St.*

15-Filed, *AUG 17 1915* *Charles M. Sinclair* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 16th, 1915
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 18th, 1915*, to *Aug 16th, 1915*, that I saw her alive on *Aug 16th, 1915*, and that death occurred, on the date stated above, at *5 P. m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix Uteri
(Blended Diagnosis)
 (Duration) *Unknown* yrs. mos. da.

CONTRIBUTORY
 (Secondary)

(Duration) *Unknown* yrs. mos. da.
 (Signed) *Walter Thomas* M. D.
Aug 16th, 1915 (Address) *1228 N. Carroll St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. *29* ds. In the State *58* yrs. *9* mos. *3* ds.

Where was disease contracted, if not at place of death? *Unknown*

Former or usual residence *1729 E Federal St.*

19-PLACE OF BURIAL OR REMOVAL

Baltimore County

DATE OF BURIAL

Aug 18th, 1915

20-UNDERTAKER

Henry Storch, Inc.

ADDRESS

1301 E Bayview

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1311 E Lafayette ave* ST.; *9* WARD)2-FULL NAME *Sarah J Cloud*(Residence in Baltimore: No. *1311 E Lafayette ave* St.; *75* yrs., *8* mos. — da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

December 15th, 1839
(Month) (Day) (Year)

7-AGE,

75 yrs., *8* mos. — da.If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....*Housewife*9-BIRTHPLACE,
(State or Country),*Baltimore*10-NAME OF
FATHER,*Andrew Hunter*11-BIRTHPLACE
OF FATHER
(State or Country),*Alexandria Va*12-MAIDEN NAME
OF MOTHER*Elizabeth West*13-BIRTHPLACE
OF MOTHER
(State or Country),*Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

William Cloud
1311 E Lafayette ave

15-

Filed.....

191

Chas. M. Nicholas

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 28, 1915, to Aug 15, 1915,
that I saw h. alive on *Aug 15, 1915,*
and that death occurred, on the date stated above, at *4:10 P.m.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
Nephritis
Heart
(Duration) *2* yrs. mos. da.CONTRIBUTORY.....
(Secondary)(Duration) *2* yrs. mos. da.

(Signed).....

Aug 15, 1915 (Address).....*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted,
if not at place of death?.....Former or
usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

Aug. 15, 1915

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E Monument

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* 18th WARD)

2-FULL NAME

(Residence in Baltimore: No. *420 1/2 Carrollton Ave.* St.; yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Widow
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown
(Month) (Day) (Year)

7-AGE,

about 70 yrs.
Not known
yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework
*General*9-BIRTHPLACE,
(State or Country),*Ms.*

PARENTS.

10-NAME OF FATHER,

*Samuel Hubbell*11-BIRTHPLACE OF FATHER
(State or Country),*Not known*

12-MAIDEN NAME OF MOTHER

*Frank Tilden*13-BIRTHPLACE OF MOTHER
(State or Country),*Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edw. M. Hoop*(Address) *Mercy Hosp.*

15-

Filed *1915*

1915

Registrar. *Chas. M. Sinclair*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 17, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Aug 16, 1915*, to *Aug 17, 1915*, that I saw her alive on *Aug 17, 1915*, and that death occurred, on the date stated above, at *4:15* pm.

The CAUSE OF DEATH* was as follows:

*Chronic Interstitial Nephritis**Duration* *Not known* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Alcohol* (Duration) yrs. mos. ds.(Signed) *Edward P. Smith* M. D.*Aug 17, 1915* (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? *420 1/2 Carrollton Ave.*Former or usual residence *420 1/2 Carrollton Ave.*

19-PLACE OF BURIAL OR REMOVAL,

St. Peters Maus.

DATE OF BURIAL,

Aug 17, 1915

20-UNDERTAKER

John J. Brown

ADDRESS

Low 901 Hollister

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87541

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6-8 W. Hill

ST.;

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Hyman Feinsinger

(Residence in Baltimore: No. 6-8 W. Hill

St.; 5 yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-STATUS,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

1840
(Month) (Day) (Year)

7-AGE,

75

yrs. - mos. - ds.

If LESS than 1 day,

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Shechter (over)

9-BIRTHPLACE,
(State or Country),

Russia

PARENTS.

10-NAME OF FATHER,

Abraham Feinsinger

11-BIRTHPLACE OF FATHER
(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Goldie "Unknown"

13-BIRTHPLACE OF MOTHER
(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Susha

(Address) 423 S. Loop St.

15-

Filed

AUG 17 1915

191

Chas. M. Fudair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July - 10 - 1915, to Aug - 16, 1915, that I saw him alive on Aug., 9, 1915, and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 5 yrs. - mos. - ds.

CONTRIBUTORY
(Secondary)

Cardiac Paralysis

(Duration) yrs. - mos. - ds.

(Signed) O. Dranskin M. D.

Aug - 16, 1915. (Address) 122 W. Lee St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. - mos. - ds. In the State yrs. - mos. - ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Feinsinger

Aug 17, 1915

20-UNDERTAKER

ADDRESS 1107 E

over

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

REGISTERED NO.

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

widowed

6-DATE OF BIRTH,

Nov

16th

1837

(Month)

(Day)

(Year)

7-AGE,

77 yrs. 9 mos. da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

at home

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Louisiana

PARENTS.

10-NAME OF FATHER,

William Winchester

11-BIRTHPLACE OF FATHER (State or Country),

Kentucky

12-MAIDEN NAME OF MOTHER

Annie Pedercleaux

13-BIRTHPLACE OF MOTHER (State or Country),

Louisiana

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Charles M. Harwood

(Address),

Judson Hall

15-

Filed

AUG 17 1915

Chas. M. Mueller

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug

16

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 13 1915, to Aug. 16 1915,

that I saw her alive on Aug. 15 1916,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Cancer of Pancreas

(Duration) yrs. 5 mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. Gibson, M. D.

Aug. 16, 1915 (Address) Roland Park, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Shelbyville Ky Aug. 15th 1915

20-UNDERTAKER,

ADDRESS

New Jenkins Sons Co McCall + Orchard St

17. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87543

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87543

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 152 N Lakewood Ave St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Madelaine Maisy Osbourne

(Residence in Baltimore: No. 152 N Lakewood Ave St. 6 yrs. 11 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH June 22, 1915
(Month) (Day) (Year)

7 AGE 1 yrs. 1 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION Infant
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) St. Agnes Hospital

10 NAME OF FATHER William Ernest Osbourne

11 BIRTHPLACE OF FATHER (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Carrie Martha Shock

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. Osbourne

(Address) 152 N Lakewood Ave

15 AUG 17 1915 Filed 191 Chas. M. Sinclair REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 16, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1915, to Aug 16, 1915, that I saw her alive on Aug 9, 1915, and that death occurred, on the date stated above, at 4:50 pm. The CAUSE OF DEATH* was as follows:

Septicaemia
multiple skin pustules
umbilical infection(?)

(Duration) 1 yrs. 1 mos. 14 ds.
Contributory (SECONDARY) Gastro enteritis?

(Signed) J. Hopmann M. D. Aug 16, 1915 (Address) St Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 1 yrs. 1 mos. 14 ds. In the State 1 yrs. 1 mos. 14 ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore cemetery DATE OF BURIAL Aug 17, 1915

20 UNDERTAKER W. M. Watson ADDRESS 230 N. Green

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *913 Plum alley* ST. *23* WARD)

2-FULL NAME

(Residence in Baltimore: No. *913 Plum alley* St. *44* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Black

5-SINGLE,

MARRIED, *Married*

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

42 yrs. mos. ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Iron Foundry*(b) General nature of industry, business, or establishment in which employed (or employer), *Calumet*

9-BIRTHPLACE,

(State or Country), *Maryland*10-NAME OF FATHER, *James Brooks*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Rebecca Brooks (wife)*(Address), *913 Plum alley*

15-

Filed, *Aug 17 1915*

191

Chas. M. Snelson

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 16, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug. 15, 1915*, to *Aug. 16, 1915*, that I saw him alive on *Aug. 16, 1915*, and that death occurred, on the date stated above, at *9 A.M.*

The CAUSE OF DEATH* was as follows:

*Primary acute Bright's disease
immediate uraemia & exhaustion*(Duration) yrs. mos. ds. *4*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. *4*(Signed) *J. P. Strong* M. D.*8/16, 1915* (Address) *506 Haverhill St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Not Auburn St

DATE OF BURIAL,

Aug. 18, 1915

20-UNDERTAKER

L. H. Brown and Sons

ADDRESS

10820 Montg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *714 Cedar Alley* ST. *4* WARD)2-FULL NAME *Edw. Johnson*(Residence in Baltimore: No. *714 Cedar Alley* St. *10* yrs., *10* mos. *10* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *Caucasian*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, *Oct. 15, 1904*

(Month)

(Day)

(Year)

7-AGE, *10* yrs., *10* mos., *10* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.

10-NAME OF FATHER, *Chas. E. Johnson*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER, *Ella Combs*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Chas. E. Johnson*(Address) *714 Cedar Alley*

15-

Filed *AUG 17 1915**Chas. M. Swelart*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 15, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug. 15, 1915*, to *Aug. 15, 1915*,that I saw him alive on *Aug. 14, 1915*,and that death occurred, on the date stated above, at *11 AM*

The CAUSE OF DEATH* was as follows:

*Acute Myocarditis**duration*

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) *typhoid fever*

(Duration) ... yrs. ... mos. ... ds.

(Signed) *M. C. Trulinger* M. D.*Aug. 16, 1915* (Address) *687 Columbia St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *mt auburn*DATE OF BURIAL, *aug. 18, 1915*20-UNDERTAKER *L. L. Brown*ADDRESS *108 W. Mount St.*

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT-CITY OF BALTIMORE

C87546

CERTIFICATE OF DEATH

Behnke
104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2512 Fairview St.)

WARD 1

2-FULL NAME

Catherine Behnke

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2512 Fairview St.; yrs. 4 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
6-DATE OF BIRTH Jan 18, 1913 (Month) (Day) (Year)	7-AGE 29 yrs. 4 mos. 29 ds. If LESS than 1 day, hrs. or min.?	
8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Home		
9-BIRTHPLACE (State or country) Balt. Md.		
PARENTS	10-NAME OF FATHER Charles Behnke	
	11-BIRTHPLACE OF FATHER (State or country) Balt. Md.	
	12-MAIDEN NAME OF MOTHER Catherine Behnke	
	13-BIRTHPLACE OF MOTHER (State or country) Balt. Md.	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

AUG 17 1915

Chas. M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
Aug 17, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15, 1915, to Aug 17, 1915, that I saw h. alive on Aug 17, 1915, and that death occurred, on the date stated above, at 10:20 a.m. The CAUSE OF DEATH* was as follows:

Acute Enteric Colitis
(Duration) yrs. mos. 17 ds.

Contributory (SECONDARY) Acute Enteric Colitis
(Duration) yrs. mos. 19 ds.
(Signed) H. J. [Signature] M. D.
Aug 17, 1915 (Address) 5100 [Address]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL
Mt Carmel
DATE OF BURIAL
Aug 19, 1915

20-UNDERTAKER
H. Sander & Sons, 1701 [Address]

C87517 HEALTH DEPARTMENT—CITY OF BALTIMORE

PLACE OF DEATH

CITY OF BALTIMORE: (No. *119*)

CERTIFICATE OF DEATH.

FULL NAME

William P. Burch

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *2695 St. Benedict St.*)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

May 30, 1858

(Month) (Day) (Year)

7-AGE,

*57**2* yrs. *17* mos. *17* da.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION,

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Painter*

9-BIRTHPLACE, (State or Country)

Washington Ill

10-NAME OF FATHER,

Wm Burch

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Burch*(Address) *2695 St. Benedict St.*

15-

Filed

AUG 17 1915

191

Chas M. Burch

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 17th 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 10th 1915*, to *Aug 17th 1915*, that I saw him alive on *Aug 17th 1915*, and that death occurred, on the date stated above, at *4:20 P.M.* The CAUSE OF DEATH* was as follows:*Uraemia*

CONTRIBUTORY (Duration) yrs. mos. ds.

(Secondary)

Nephritis

(Signed)

Aug 17th 1915(Address) *Wm. Burch*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs. mos. ds.

7

In the State

yrs. mos. ds.

?

Where was disease contracted, if not at place of death?

?

Former or usual residence

2695 St. Benedict St.

19-PLACE OF BURIAL OR REMOVAL

London Park Cem.

DATE OF BURIAL

Aug 19, 1915

20-UNDERTAKER

Edna Cook

ADDRESS

77 E. 76th Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PHYSICIANS should state

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. WARD)

FULL NAME

(Residence in Baltimore: No.

St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and Room No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH

AGE

If LESS than 1 day, hrs. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country)

NAME OF FATHER

BIRTHPLACE OF FATHER (State or country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (State or country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

Aug. 16, 1915, to Aug. 16, 1915.

that I saw him alive on Aug. 16, 1915.

and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Cholera - infantum

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Arthur E. Tappan M. D.

Aug. 16, 1915 (Address) 2733 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

087549

CERTIFICATE OF DEATH

79 087549
REGISTERED NO. C.

1 PLACE OF DEATH

Little Sisters of the Poor

CITY OF BALTIMORE: (No.

St. *10* WARD)

2-FULL NAME

Frank Reel

(Residence in Baltimore: No.

Little Sisters of the Poor

St.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

life time

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

Unknown

(Day)

1850

(Year)

7-AGE

65

yrs.

mos.

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Baltimore Md

10-NAME OF FATHER

James Reel

11-BIRTHPLACE OF FATHER (State or country)

Balto Md

12-MAIDEN NAME OF MOTHER

Mary Corbitt

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sister Benedict

(Address)

Little Sisters of the Poor

15-

Filed

191

Chas M. Sander

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 17

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

No record

191

to

191

that I saw him alive on *Aug 15* 191

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart

Unknown

(Duration)

yrs.

mos.

ds.

Contributory (SECONDARY)

(Signed), *F. Warner*

M. D.

Aug 17

191

[Address]

1133 Valley St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

5

yrs.

8

mos.

ds.

In the

life time

Where was disease contracted, If not at place of death?

Former or usual residence

Unknown

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral

Aug 19, 1915

20-UNDERTAKER

J. C. Cook

ADDRESS

502 E. Ward

C87550

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87550

CERTIFICATE OF DEATH.

REGISTERED NO. 5

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 W Pratt

ST. 19 WARD)

2-FULL NAME Frank C Heinzenberger

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1805 W Pratt

St.; 25 yrs., 5 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

February 3, 1890
(Month) (Day) (Year)

7-AGE,

25

5 yrs., 12 mos., 12 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Produce Dealer

9-BIRTHPLACE,
(State or Country),

Maryland, Balto City

10-NAME OF FATHER,

Conrad Heinzenberger

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Mary Oswald

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Heinzenberger

(Address) 2017 Ramsay St.

15-

AUG 17 1915

Filed..... 191.....

HARRY O. ANDREWS

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 3, 1915, to Aug 15, 1915,

that I saw him alive on Aug 15, 1915,

and that death occurred, on the date stated above, at 12:45 P. M.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) Walter A. Ford M. D.

Aug 17, 1915. (Address) Garrison Building

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL,

Aug 18, 1915

ADDRESS

1531 W. Lombard St.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. 10 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str. 7 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Colored 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH Not known, 1908 (Month) (Day) (Year)

7-AGE 7 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION Child (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE Baltimore Md. (State or country)

10-NAME OF FATHER John Fleming

11-BIRTHPLACE OF FATHER Maryland (State or country)

12-MAIDEN NAME OF MOTHER Susan Whittier

13-BIRTHPLACE OF MOTHER Md. (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Ringold (Address) 839 Mc. Clure St.

15-AUG 17 1915 HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH August 11, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 1, 1915 to August 11, 1915 that I saw him live on August 10, 1915 and that death occurred, on the date stated above, at 4 P. M. The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

Contributory (SECONDARY) Exhaustion (Duration) yrs. 3 mos. ds.

(Signed) P. E. Kelly M. D. Aug 16, 1915 (Address) Dr. E. Kelly

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Prince Georges Co. Md. DATE OF BURIAL Aug 17, 1915

20-UNDERTAKER Robert A. Elliott 506 Rodger Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *920 N Central Ave* St.; *10* WARD)

2-FULL NAME

(Residence in Baltimore: No. *920 N Central Ave* St.; *10* yrs. *10* mos. *10* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Aug 16, 1915
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day.

1 yrs. *1* mos. *1* da.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Balto City Md

PARENTS.

10-NAME OF FATHER,

John Herschner

11-BIRTHPLACE OF FATHER (State or Country),

Annerca Md

12-MAIDEN NAME OF MOTHER,

Caroline M Fischer

13-BIRTHPLACE OF MOTHER (State or Country),

Annerca Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Herschner*(Address) *920 N Central Ave*

15-

Filed

AUG 17 1915

191

HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 17, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 17 1915*, to *Aug 18 1915*, that I saw him alive on *1915*, and that death occurred, on the date stated above, at *114 m.*

The CAUSE OF DEATH* was as follows:

*Premature Birth
Age 7 Gestation about
3 months*(Duration) *1* yrs. *1* mos. *1* da.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs. *1* mos. *1* da.(Signed) *John M. Fisher* M. D.*Aug 17, 1915* (Address) *920 N Central Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *1* da. In the *1* yrs. *1* mos. *1* da. State *1* yrs. *1* mos. *1* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Cross Cemetery Aug 17, 1915

20-UNDERTAKER

ADDRESS

Henry Kovich - 1301 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

887553

64

887553

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 17)

WARD

2-FULL NAME

(Residence in Baltimore: No. 1028)

St.; - yrs. - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from August 11th, 1915, to August 16th, 1915, that I saw her alive on August 16th, 1915, and that death occurred, on the date stated above, at 4 a.m. The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

AUG 17 1915

Filed 191

HARRY O. ANDREWS,

REGISTRAR

Wm. A. Elliott

508 N. Rogers Ave.

C87551

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *506 Albemarle* ST.; *3* WARD)

2-FULL NAME

Victoria Milano

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *506 Albemarle*St.; *✓* yrs., *—* mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

August 26, 1866
(Month) (Day) (Year)

7-AGE,

48 yrs., 11 mos., 15 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*House Wife*

9-BIRTHPLACE, (State or Country),

Italy

10-NAME OF FATHER,

Not Known

11-BIRTHPLACE OF FATHER (State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER (State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rosa M. Milano*(Address) *506 Albemarle St.*

15-

AUG 17 1915

HARRY O. ANDREWS,

Filed *191* *Mar 1st* *Permit* *31st* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 15, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb 17* 191*3*, to *Aug 15* 191*5*, that I saw h *alive* on *Aug 14* 191*5*, and that death occurred, on the date stated above, at *3:4* m.

The CAUSE OF DEATH* was as follows:

Chronic Degeneration
(Duration) *2 yrs., 6 mos., 15 ds.*

CONTRIBUTORY (Secondary)

(Signed) *S. J. ...* M. D.
(Address) *1105 4th St. S. E. Wash. D. C.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1 yr., 3 mos., 15 ds.* In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

910 E. ... Alley

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

Aug 17, 1915

20-UNDERTAKER

Mundell & Appel 220

ADDRESS

378 Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Guilford Ave. ST. 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Walmsley

(Residence in Baltimore: No. 1810 Guilford Ave.

St. 26 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

March 12 1855, 1 (Month) (Day) (Year)

7-AGE,

60 yrs. 5 mos. 4 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Retired Police
(b) General nature of industry, business, or establishment in which employed (or employer). Seargeant

9-BIRTHPLACE, (State or Country),

Cecil Co., Md.

10-NAME OF FATHER,

Benjamin F. Walmsley

11-BIRTHPLACE OF FATHER (State or Country),

Cecil Co., Md.

12-MAIDEN NAME OF MOTHER

Francis W. Briscoe

13-BIRTHPLACE OF MOTHER (State or Country),

Cecile Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank J. Murphy

(Address) City Hall, Baltimore

15-

AUG 17 1915

Filed 1915

HARRY O. ANDREWS

Marital Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 16, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1915, to Aug 16 1915, that I saw him alive on Aug 15, 1915, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion, Bore mouth, Heart failure, Arterio Scler. 10 yrs. Acute sub. hemorrh. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Aug 17, 1915 (Address) 108 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Francis Xavier Cemetery, Cecil Co., Md.

DATE OF BURIAL,

Aug 18, 1915

20-UNDERTAKER

Henry W. & Mary E. Son

ADDRESS

8057 N. Calvert

Via P.O. R.R. - Frank J. Murphy to accompanying Remains

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2423 Harlem ave ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2423 Harlem ave St.; Life time yrs. 0 mos. 0 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE,

Widowed
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 20th, 1846
(Month) (Day) (Year)

7-AGE,

69 yrs. 0 mos. 27 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Machinist9-BIRTHPLACE.
(State or Country),City

10-NAME OF FATHER,

George Stohmeyer

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. Henry Stohmeyer(Address) Quinn ave 126 16

15-AUG 17 1915

HARRY O. ANDREWS,

Filed..... 1915 Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 17th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended decensed from

Aug 16 1915, to Aug 17 1915,that I saw him alive on Aug 16 1915,and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Chr. endocarditis(Duration) 3 yrs. 0 mos. 0 ds.CONTRIBUTORY
(Secondary)Arterio-sclerosis(Duration) 7 yrs. 0 mos. 0 ds.

(Signed)

Wm. U. Todd M. D.
Aug 17 1915. (Address) 737 N. Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Baltimore Amity Aug 19th, 1915

20-UNDETAILED

ADDRESS

Gr. Weber & Son 2503 Edmondson ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87558

C87558

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Md. Gen. Hosp

REGISTERED NO. C

CITY OF BALTIMORE; (No.

ST. 11

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Norman Heacock

(Residence in Baltimore: No.

MD General Hospital

St.; yrs. mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

October 25

1905

(Month)

(Day)

(Year)

7-AGE,

9 yrs. 9 mos. 23 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

School Boy

9-BIRTHPLACE,

(State or Country).

Franklinstown Md

10-NAME OF FATHER,

Charles L. Heacock

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore Co. Md

12-MAIDEN NAME OF MOTHER

Lillie Butler

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas. L. Heacock

(Address)

Franklinstown Md

15-

AUG 17 1915

Filed

191

Marial Permit Olay

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August

17

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 6 1915, to Aug 17 1915,

that I saw him alive on Aug 17 1915,

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Appendectomy)

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY

(Secondary)

Acute cardiac dilatation

post op shock (Duration) yrs. mos. 3 ds.

(Signed) A. C. Smith M. D.

Aug 17, 1915. (Address) 4509 Liberty St. W. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the 9 yrs. 9 mos. 13 ds. State

Where was disease contracted,

if not at place of death

Home

Former or usual residence

Franklinstown Md

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Calverton

Aug 19 1915

20-UNDERTAKER

ADDRESS

Jas. B. Cook

1003 N. Baltimore St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1318 Steever

2-FULL NAME

William F. Kraus

(Residence in Baltimore: No. 1318 Steever

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 7th, 1878 (Month) (Day) (Year)

7-AGE, 37 yrs. 1 mos. 9 ds. If LESS than 1 day, hrs. or mins.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer). Printer

9-BIRTHPLACE, (State or Country). Md

10-NAME OF FATHER, Charles L. Kraus

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Catherine Binding

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. H. Allen (Address) 1318 Steever St.

15- AUG 17 1915 Filed 1915 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 16th, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) E. J. Ryan, M. D. (Coroner)

Aug 17, 1915. (Address) 423 N. Broadway *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Swoartz's Cem. DATE OF BURIAL, Aug 18th, 1915

20-UNDERTAKER, Geo J. Rutt ADDRESS, 1735 Harford Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87560

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 N. Saratoga ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out Nos. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1303 N. Saratoga St.; yrs., 1 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

(Month) July (Day) 3, (Year) 1915

7-AGE,

yrs. 1 mos. 13 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country)

Baltimore City

10-NAME OF FATHER

William E. Davis

11-BIRTHPLACE OF FATHER

(State or Country),

N.Y.

12-MAIDEN NAME OF MOTHER

Rose E. Small

13-BIRTHPLACE OF MOTHER

(State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm E. Davis(Address) 1303 N. Saratoga

15-AUG 18 1915

Filed.....

1915

Chas. M. Sinclair

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) Aug (Day) 16, (Year) 1915

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 16 1915, to Aug. 16 1915,that I saw her alive on Aug. 16 1915,and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Brucella Pneumonia

.....

..... (Duration)..... yrs..... mos. 7 ds.CONTRIBUTORY
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) J. H. Tamm M. D.Aug. 17, 1915. (Address) 317 N. Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cemetery Aug. 18, 1915.

20-UNDERTAKER

ADDRESS

Arthur C. Fuller 221 N. Broadway

Cause of death in plain terms, as far as it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87561

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 C87561

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19)

2-FULL NAME

(Residence in Baltimore: No. 19)

REGISTERED No. C.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male
4-COLOR OR RACE White
5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
6-DATE OF BIRTH Aug. 15, 1914
7-AGE 1 yrs. 1 mos. 1 ds. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Calvert, Leo. Md.

10-NAME OF FATHER Thos. P. Tucker
11-BIRTHPLACE OF FATHER (State or country) Calvert, Leo. Md.
12-MAIDEN NAME OF MOTHER Leollie Cochrane
13-BIRTHPLACE OF MOTHER (State or country) Calvert, Leo. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Leollie Tucker (Address) 102 W. Meath St.

15- AUG 18 1915 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug. 16, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 4, 1915, to Aug. 16, 1915, that I saw him alive on Aug. 16, 1915, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

Contributory (SECONDARY) Malnutrition (Duration) yrs. 14 mos. ds. (Signed) Edgar B. Wedemeyer M. D. Aug. 16, 1915. [Address] 1616 E. 1st Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. 1 mos. 12 ds. State yrs. mos. ds. Where was disease contracted? If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Aug. 18, 1915 20-UNDERTAKER C. Scholman & Son ADDRESS 1039 Hanover St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *775 N Saratoga* ST. *4* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *775 N Saratoga* St.; *41* yrs., *X* mos., *X* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE.

*Wh*5-SINGLE,
MARRIED,
WIDOWED,
OR-DIVORCED.
(Write the word.) *married*

6-DATE OF BIRTH.

....., *1*.....
(Month) (Day) (Year)

7-AGE.

64 yrs. *✓* mos. *✓* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*Housewife*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

Manguns Voigt

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

Chas A Abicht
775 N Saratoga St

15-

Filed.....

191.....

Chas M Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 15....., *1915*.....
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 18*....., *1915*....., to *Aug 15*....., *1915*.....that I saw h *er* alive on *Aug 15*....., *1915*....., and that death occurred, on the date stated above, at *8 P* m.

The CAUSE OF DEATH* was as follows:

Chronic Interrenal Nephritis(Duration)..... yrs. *2* mos. *15* ds.CONTRIBUTORY
(Secondary)(Duration)..... yrs. *✓* mos. *✓* ds.(Signed) *August Horn*..... M. D.*Aug 16*....., *1915*..... (Address) *4 P 8 25 St N*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*London Park Cemetery**Aug 18*....., *1915*.....

20-UNDERTAKER

ADDRESS

*Mrs G Rohde Son**730 Pa Ave*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *133 N. Dallas* ST.; *6* WARD)

2-FULL NAME

(Residence in Baltimore: No. *133 N. Dallas* St.; *life time* yrs., *0* mos. *0* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

widow

6-DATE OF BIRTH,

Unknown, 1852
(Month) (Day) (Year)

7-AGE,

63 yrs. *0* mos. *0* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housework*
at home

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. Lee*(Address) *133 N. Dallas*

15-

Filed

191

Wm. Lee

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

26 11 1915, to *Aug 16 1915*that I saw him alive on *Aug 15 1915*and that death occurred, on the date stated above, at *23 04* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Paralysis
(Duration) *6* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

(Duration) *0* yrs. *0* mos. *0* ds.(Signed) *W. C. Burman, Jr.*191... (Address) *22 183 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. John's Cemetery

DATE OF BURIAL,

Aug. 17, 1915

20-UNDERTAKER

Robt. A. Elliott

ADDRESS

506 1/2 Boggs Ave.

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 59 yrs. 8 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6-DATE OF BIRTH December 10, 1855 (Month) (Day) (Year)

7-AGE 59 yrs. 8 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Marketman

9-BIRTHPLACE (State or country) Baltimore

10-NAME OF FATHER John Steinmier

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Arthur Hamilton

13-BIRTHPLACE OF MOTHER (State or country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Hoffman

(Address) 1424 N. Gay

15- AUG 18 1915 Filled 1915 Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH August 17, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 1912, to August 1915, that I saw him live on Aug. 16, 1915, and that death occurred, on the date stated above, at 5 P. M. The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

Contributory (SECONDARY) arterio-sclerosis

(Signed) William Francis M. D. (Address) 1424 N. Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL BALTIMORE CEMETARY. DATE OF BURIAL AUG 18 1915

20-UNDERTAKER ADDRESS ARMSTRONG-DENNY CO. 715 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2324 E Madison* ST. *7* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Margaretta N. Vogler*(Residence in Baltimore: No. *2324 E Madison St* Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH

*May**18**1899*

(Month)

(Day)

(Year)

7-AGE

*66**3*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country)

Baltimore

10-NAME OF FATHER

George Euler

11-BIRTHPLACE OF FATHER (State or Country)

Germany

12-MAIDEN NAME OF MOTHER

Martha Lachse

13-BIRTHPLACE OF MOTHER (State or Country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

George Vogler

(Address)

2324 E Madison St

15-

Filed

*AUG 18 1915**Chas M. McClair*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Aug**16**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Aug 1**1913*

to

*Aug 16**1915*that I saw him alive on *Aug 16* *1915*and that death occurred, on the date stated above, at *6* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis (Duration) yrs. mos. ds.(Signed) *Alvin B. Leman* M. D.*Aug 17*, 1915. (Address) *718 N Patterson St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Baltimore Cemetery**Aug 18*, 1915.

20-UNDERTAKER

ADDRESS

*H. Sander Sons**1210 E. 11th St.*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2209 Essex ST. 1 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2209 Essex St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH.

May 29, 1856
(Month) (Day) (Year)

7-AGE.

39 yrs. 2 mos. 15 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Watchman

9-BIRTHPLACE, (State or Country).

Balti City M. d.

10-NAME OF FATHER.

John A. Frederick

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Annie Hansen

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Lora Frederick

(Address).

2209 Essex St

15-

AUG 18 1915

Chas M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov. 5, 1914, to Aug 15, 1915that I saw him alive on Aug 14, 1915, and that death occurred, on the date stated above, at 10:15 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue
(Duration) 9 yrs. 9 mos. 9 ds.

CONTRIBUTORY (Secondary)

General Exhaustion
(Duration) 2 yrs. 2 mos. 2 ds.

(Signed)

J. C. Sinclair M. D.
Aug 17/15 (Address) 25 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 1 yrs. 2 mos. 2 ds. In the State 1 yrs. 2 mos. 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mount Carmel Cem.Aug 18, 1915

20-UNDERTAKER

ADDRESS

H. Sander & Sons1710 E. Pratt St.

important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87537

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87537

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

3334 Old Frederick St.

WARD)

2-FULL NAME

Elizabeth M. Herzog

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

3334 Old Frederick St.

yrs. 2 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

Aug (Month) 2 (Day) 1915 (Year)

7-AGE

yrs. 2 mos. 14 ds. or min.?

If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Balto

10-NAME OF FATHER

Harry Herzog

11-BIRTHPLACE OF FATHER (State or country)

Balto

12-MAIDEN NAME OF MOTHER

Margaret Twist

13-BIRTHPLACE OF MOTHER (State or country)

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Herzog

(Address) 3334 Old Frederick St.

15-

Filed

AUG 18 1915

Chas M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug. 17, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 16, 1915, to Aug 17, 1915.

that I saw him alive on 11 P M, 1915

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Acute gastric indigestion

(Duration) yrs. mos. 2 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) M. A. McElroy M. D.

Aug 17, 1915 (Address) 4207 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore City Aug 18, 1915

20-UNDERTAKER

ADDRESS

Wm. F. Fields 1200 N. Lombard

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hosp.* ST.; *22* WARD)2-FULL NAME *Lottie Hundley*(Residence in Baltimore: No. *737* *Dover St.* St.; *4* yrs., *—* mos. *—* ds.)REGISTERED No. C *122*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *female*4-COLOR OR RACE, *Blk*5-SINGLE, *Married*
MARRIED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Aug. 13* 1880
(Month) (Day) (Year)7-AGE, *35* yrs. *—* mos. *—* ds. If LESS than 1 day, *—* hrs. or *—* min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *H.W.*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Jasper Foster*11-BIRTHPLACE OF FATHER (State or Country), *Mass.*12-MAIDEN NAME OF MOTHER, *Mandy Gustus*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. S. Coleman M.D.*(Address) *University Hosp.*15- *Aug. 18* 1915 *1915**Chas. M. McClair* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 16* 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug. 13* 1915, to *Aug. 16* 1915, that I saw her alive on *Aug. 16* 1915, and that death occurred, on the date stated above, at *12:30 P.M.*

The CAUSE OF DEATH* was as follows:

*Pneumonia*CONTRIBUTORY (Secondary) *Surgical shock*
(Duration) *1 1/2 hrs.*(Signed) *A. S. Coleman* M. D.
Aug. 16 1915. (Address) *University Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *—* mos. *—* ds. In the *lifetime* State *—* yrs. *—* mos. *—* ds.Where was disease contracted, *Former residence* if not at place of death?Former or usual residence *737 Dover St.*19-PLACE OF BURIAL OR REMOVAL, *St. Michael's*DATE OF BURIAL, *Aug. 19* 191520-UNDERTAKER, *John H. Toadum*ADDRESS *142 St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87569

1-PLACE OF DEATH

29
REGISTERED NO. C

CITY OF BALTIMORE (No. 1304 E Baltimore St.

ST. 5

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Bennie Hirschowitz

(Residence in Baltimore: No. 1304 E Baltimore St.

St. 3 yrs. 10 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

single

6-DATE OF BIRTH

Oct. 1, 1901
(Month) (Day) (Year)

7-AGE

13 yrs. 10 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

school-boy

9-BIRTHPLACE
(State or country)

Baltimore

10-NAME OF FATHER

Joseph Hirschowitz

11-BIRTHPLACE OF FATHER
(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Rebecca Kaplan

13-BIRTHPLACE OF MOTHER
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Hirschowitz

(Address)

1304 E Baltimore St

15

AUG 18 1915

Chas. H. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug. 18, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 1911, to Aug. 18, 1915.

that I saw him alive on Aug. 17, 1915.

and that death occurred, on the date stated above, at 2:50 p. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart
(Mitral Stenosis & Insufficiency)

(Duration) 5 yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) David J. Macht M. D.

Aug. 18, 1915 (Address) 3218 Audubon Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

1304 E Balto St

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Lawrence Cemetery

Aug. 18, 1915

20-UNDERTAKER

ADDRESS

S. Linnson & Co. Balto St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 Carlton ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 231. Carlton St. St.; 10 yrs., 10 mos., 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

Col5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH,

Oct 7, 1914
(Month) (Day) (Year)

7-AGE,

10 MoIf LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Infant9-BIRTHPLACE,
(State or Country),Balt Md

10-NAME OF FATHER,

John D. Peterson11-BIRTHPLACE OF FATHER
(State or Country),Balt Md

12-MAIDEN NAME OF MOTHER

May D. Jensen13-BIRTHPLACE OF MOTHER
(State or Country),Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed AUG. 18 1915Chas M. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 16, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1915, to Aug 16 1915, that I saw her alive on Aug 16 1915, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

J. H. Jackson M. D.917, 1915 (Address) 112 N. Carroll

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McAuliffe Mt. Auburn Aug. 18, 1915

20-UNDERTAKER

ADDRESS

Frederick J. Ireland 14 N. Schuyler

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *734 Wasche*)ST.; *4* WARD)REGISTERED NO. C *79*

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Annie Josephine Brown*(Residence in Baltimore: No. *734 Wasche*)St.; *40* yrs., *-* mos., *-* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*6-DATE OF BIRTH, *July 1, 1857*

(Month)

(Day)

(Year)

7-AGE, *64* yrs., *-* mos., *-* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *Henson Smith*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER, *Matilda Boyer*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charlotte Whiting Sister*(Address) *1604 Division Street*

15-

Filed *AUG 18 1915*

191

Chas. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug - 16, 1915*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 1, 1915* to *Aug 13, 1915*, that I saw her alive on *Aug 15, 1915*, and that death occurred, on the date stated above, at *6 P.* m.

The CAUSE OF DEATH* was as follows:

*Mitral Insufficiency*CONTRIBUTORY (Secondary) *Exhaustion*(Signed) *J. P. Hughes*

Aug 17, 1915

(Address) *1443 S. Hill St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *West Auburn Cemetery*DATE OF BURIAL, *Aug 18 1915*20-UNDERTAKER, *Rev. H. Holland*ADDRESS, *517 Robert St.*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hospital* ST.; *2* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *612 8 Regester* St.; *38* yrs., *1* mos., *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, *Married*

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

*Feb**28**1865*

(Month)

(Day)

(Year)

7-AGE,

*50**5**18**ds.*

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Labourer

(b) General nature of industry, business, or establishment in which employed (or employer).

General

9-BIRTHPLACE,

(State or Country),

Ireland

10-NAME OF FATHER,

John Boyer

11-BIRTHPLACE OF FATHER,

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER,

(State or Country),

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Julia Boyer*(Address) *1715 Eberly's Court*

15-

AUG 18 1915

Chas M. Sander

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Aug**16**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 15 1915, to *Aug 16* 1915,that I saw him alive on *Aug 15* 1915,and that death occurred, on the date stated above, at *3.30* am.

The CAUSE OF DEATH* was as follows:

*General Carcinomatous**Pyloric obstruction (complete)**Carcinoma of stomach, liver and**intestines* (Duration) *about 1 year**Advanced Diarrhoea (X-ray)*

CONTRIBUTORY (Secondary)

(Duration) *about 1 year*(Signed) *Emmet M. T. Rieger* M. D.*Aug 16, 1915* (Address) *St Josephs Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *9* mos. *9* ds. In the State yrs. *9* mos. *9* ds.Where was disease contracted, if not at place of death? *unknown*Former or usual residence *612 8 Regester St.*

19-PLACE OF BURIAL OR REMOVAL,

St Patrick's Cem.

DATE OF BURIAL,

Aug 19, 1915

20-UNDERTAKER

*H. Sander & Son*ADDRESS *1715 Eberly's Court*

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87573

C87573

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 324 S. Wolfe.

ST. WARD)

2-FULL NAME

Magdalena Borys

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 324 S. Wolfe.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARKED, WIDOWED OR DIVORCED

Single

6-DATE OF BIRTH

Aug. 17, 1915

(Month) (Day) (Year)

7-AGE

Yrs. mos. ds. or min.?

If LESS than 1 day 5 hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None
Infant

9-BIRTHPLACE
(State or country)

Baltimore

10-NAME OF FATHER

Wladyslaw Borys

11-BIRTHPLACE OF FATHER
(State or country)

Austria

12-MAIDEN NAME OF MOTHER

Josefa Jabulowicz

13-BIRTHPLACE OF MOTHER
(State or country)

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wladyslaw Borys

(Address)

324 S. Wolfe.

15-

FILED

AUG 18 1915

Chas M. Snelman

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug. 17, 1915

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 17, 1915, to Aug. 17, 1915,

that I saw her alive on Aug. 17, 1915,

and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Miscarriage.

Contributory
(SECONDARY)

Premature Birth

(Signed)

J. W. Wadsworth

M. D.

8-18-1915 (Address) 115 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence.

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary

DATE OF BURIAL

Aug. 18, 1915

UNDERTAKER

William Frantz

ADDRESS

108 E. Euter Ave

Birth Certificate of
by Taylot, Born Sept. 30th. 1914
1 S. Port St. No. B-4766
me given at time of Birth.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 S. Port

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Martin Krawczyk

(Residence in Baltimore: No. 707 S. Port.

St.; yrs. 11 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

6-DATE OF BIRTH

Sept. 30, 1914

7-AGE

yrs. 11 mos. 19 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None
Infant

9-BIRTHPLACE (State or Country)

Baltimore

10-NAME OF FATHER

Peter Krawczyk

11-BIRTHPLACE OF FATHER (State or Country)

Austria

12-MAIDEN NAME OF MOTHER

Julia Kammarski

13-BIRTHPLACE OF MOTHER (State or Country)

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Krawczyk

(Address) 707 S. Port St.

15-

AUG 18 1915

Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 18, 1915

I HEREBY CERTIFY, That I attended deceased from August 10, 1915, to August 18, 1915, that I saw him alive on August 18, 1915, and that death occurred, on the date stated above, at 3:41 m.

The CAUSE OF DEATH* was as follows:

Enteritis

CONTRIBUTORY (Secondary)

(Signed) J. J. Jannuszek, M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary

DATE OF BURIAL

Aug 17, 1915

20-UNDERTAKER

William Fiacco

ADDRESS

1618 Eastern Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Joseph Hospital

ST.: 8 WARD)

REGISTERED NO. C

2-FULL NAME

Archibald E. Martin

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1831 N. Gay St.

St.: 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

single

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

41

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

Standard Oil Works

9-BIRTHPLACE, (State or Country),

Ireland

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James Mrs. Bride

(Address)

1841 N. Montford Ave

15-

AUG 18 1915

Baltimore

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug

11

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 6

1915

to Aug 17

1915

that I saw him alive on Aug 17 1915

and that death occurred, on the date stated above, at 4:45 p.m.

The CAUSE OF DEATH* was as follows:

Alcohol Poisoning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hepatic Failure

(Duration) yrs. mos. ds.

(Signed)

Oscar V. Fairbank

M. D.

Aug 17, 1915 (Address) St. Joseph's

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? do not know

Former or usual residence 1831 N. Gay

19-PLACE OF BURIAL OR REMOVAL,

Cremated at London Park

DATE OF BURIAL,

Aug 18 1915

20-UNDERTAKER

Philip Herwig

ADDRESS

2016 Orleans St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1536 Walnut ally ST.; 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number; and fill out No. 18.)

2-FULL NAME

Thomas Parker

(Residence in Baltimore: No. 536 Walnut ally St.; yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. male

4-COLOR OR RACE

Colored.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

July 17th

1 month (Month) 1 day (Day)

1915 (Year)

7-AGE,

1 yrs. 1 mos. 1 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Maryland Baltimore

PARENTS.

10-NAME OF FATHER,

Thomas Parker

11-BIRTHPLACE OF FATHER (State or Country),

Calvert Co. Md.

12-MAIDEN NAME OF MOTHER

Marie White

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Mason

(Address)

536 Walnut ally

15-

Filed..... 1915

Chas M. Snelgar

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 17

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 28- 1915, to Aug. 17 1915,

that I saw him alive on Aug. 16- 1915,

and that death occurred, on the date stated above, at 7³⁰ a. m.

The CAUSE OF DEATH* was as follows:

Marasmus

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) Samuel A. Baur, M. D.

(Address) 937 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel Cemetery Aug. 18th 1915

20-UNDERTAKER

ADDRESS

Robert L. Parham 830 George St

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hahnemann Gen Hospital* REGISTERED NO. C
 CITY OF BALTIMORE: (No. *1122 N. Mount* ST.; *16* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 FULL NAME *Edward A. Carter*
 (Residence in Baltimore: No. *809 N. Parish* St.; *4* yrs., *4* mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, *Male* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, *Married*, WIDOWED, OR DIVORCED, (Write the word.)
 6-DATE OF BIRTH, *Dec* *24*, *1891*
 (Month) (Day) (Year)
 7-AGE, *23* yrs., *7* mos., *24* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, *Laborer*
 (b) General nature of industry, business, or establishment in which employed (or employer), *General*

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *Chas. F. Carter*
 11-BIRTHPLACE OF FATHER (State or Country), *Richmond Va*
 12-MAIDEN NAME OF MOTHER, *Georgiana Atkins*
 13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Georgia Carter*
 (Address) *809 N. Parish St.*

15- AUG 18 1915

Filed..... 191

ROBERT KRAUTER
 REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug* *16*, *1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 8th* *1915*, to *Aug 16th* *1915*, that I saw him alive on *Aug 16th* *1915*, and that death occurred, on the date stated above, at *4:45* p.m.

The CAUSE OF DEATH* was as follows:

Paralysis of Lower Extremity
& Meningitis

(Duration)..... yrs..... mos. *8* ds.

CONTRIBUTORY *Fracture of 7th Cervical vertebra*
 (Secondary) *Accident fall from porch*
 (Duration)..... yrs..... mos. *8* ds.

(Signed) *M. Bowman* M. D.
Aug 16th 1915 (Address) *626 N. Calver St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos. *8* ds. In the State *23* yrs. *7* mos. *24* ds.

Where was disease contracted, if not at place of death? *809 N. Parish St*

Former or usual residence *809 N. Parish St.*

19-PLACE OF BURIAL OR REMOVAL, *St Auburn* DATE OF BURIAL, *Aug 19, 1915*

20-UNDERTAKER, *Willie Brown* ADDRESS *316 N. Mount St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *819 S. Port* St. *1* WARD)2-FULL NAME *Leo Schrader*

(If death occurred in a hospital or institution, give its NAME; instead of street and number and RM out No. 11L)

(Residence in Baltimore: No. *819 S. Port* St.; yrs. *8* mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*Single*

6-DATE OF BIRTH

Jan
(Month)*4*, 1915
(Day) (Year)

7-AGE

7 yrs. *8* mos. *14* ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE
(State or country)*Baltimore Md.*

10-NAME OF FATHER

*Martin Schrader*11-BIRTHPLACE OF FATHER
(State or country)*Germany*

12-MAIDEN NAME OF MOTHER

*Johanna Rudzinski*13-BIRTHPLACE OF MOTHER
(State or country)*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Johanna Schrader*(Address) *819 S. Port St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 18, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Aug 16*, 1915, to, *Aug 18*, 1915, that I saw *him* alive on *Aug 18*, 1915, and that death occurred, on the date stated above, at *7:20* a.m.
The CAUSE OF DEATH* was as follows:
*Menigitis*Contributory
(SECONDARY)(Signed) *Dr. J. H. Smith* M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Stanislaus

DATE OF BURIAL

Aug 19, 1915

20-UNDERTAKER

M. J. Sadrowski

ADDRESS

705 S. Ann St

15-

AUG 18 1915

ROBERT KRAUTER
Burial Permit Clerk

REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87579		HEALTH DEPARTMENT-CITY OF BALTIMORE		79 87579	
PLACE OF DEATH		CERTIFICATE OF DEATH		REGISTERED NO. C	
CITY OF BALTIMORE (No. 1566 Ridgely		ST. 21 WARD)		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
2-FULL NAME Sarah E Gathe		St. 5 yrs. mos. ds.)			
(Residence in Baltimore: No. 1566 Ridgely st					
PERSONAL AND STATISTICAL PARTICULARS					
3-SEX Female	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married	16-DATE OF DEATH August 18, 1915 (Month) (Day) (Year)		
6-DATE OF BIRTH March 28, 1895 (Month) (Day) (Year)			17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1915 to Aug 18, 1915 that I saw her alive on Aug 18, 1915 and that death occurred, on the date stated above, at 11:30 a.m. The CAUSE OF DEATH* was as follows: Myocarditis		
7-AGE 70 yrs. 4 mos. 21 ds. or less than 1 day, hrs. min.?			Contributory (SECONDARY) Easutis (Duration) ? yrs. mos. ds.		
8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None			(Signed) James A. Duff M.D. Aug 18, 1915 (Address) Crescent Md.		
9-BIRTHPLACE (State or country) Maryland			*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
PARENTS	10-NAME OF FATHER Ruben Jip		18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence		
	11-BIRTHPLACE OF FATHER (State or country) Maryland		19-PLACE OF BURIAL OR REMOVAL Baltimore Cemetery		
	12-MAIDEN NAME OF MOTHER Unknown		DATE OF BURIAL Aug 21, 1915		
	13-BIRTHPLACE OF MOTHER (State or country) Maryland		20-UNDERTAKER Address Lillian Syke 1600 W. North m		
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Thomas B Gathe					
15-AUG 18 1915 ROBERT KRAUTER Filed, 191 Mortal Permit Clerk REGISTRAR					

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87581

C87581

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST. 6 WARD)

FULL NAME

217 N. Chapel
Sabina T Schrieber(If death occurred in
a hospital or institution,
give its NAME instead of
street and number and
fill out No. 18.)

(Residence in Baltimore: No.

217 N. Chapel

St. 5 yrs. — mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

July

28, 1910

(Month)

(Day)

(Year)

7-AGE

5

yrs.

—

mos.

20

ds.

IF LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Baltimore

10-NAME OF
FATHER

Jos G Schrieber

11-BIRTHPLACE
OF FATHER
(State or country)

Germany

12-MAIDEN NAME
OF MOTHER

Theresa Helget

13-BIRTHPLACE
OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jos G Schrieber

(Address)

217 N. Chapel St

AUG 18 1915

Filed

191

ROBERT . KRAUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

Aug

17, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 - 1915 to Aug 16 1915.

that I saw her alive on Aug 16, 1915.

and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) — yrs. — mos. 16 ds

Contributory
(SECONDARY)

Meningitis

(Duration) — yrs. — mos. 7 ds.

(Signed)

H. T. Rader

M. D.

Aug 17, 1915 (Address) 1202 E. Bay View St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,
or Recent Residents)At place
of death yrs. mos. ds. State yrs. mos. ds.Where was disease contracted,
if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Redeemer Cem.

DATE OF BURIAL

Aug 17, 1915

20-UNDERTAKER

Lilly and Zeller

ADDRESS

403 S. W. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Joseph Hospital

ST.; 9 WARD)

REGISTERED NO. C

2-FULL NAME

Vilma Barnes

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

142 N. Eighth St.

St.; 29 yrs., 5 mos., 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE, (MARRIED, WIDOWED, OR DIVORCED, Write the word.) married

6-DATE OF BIRTH,

Feb. 27th, 1886

(Month) (Day) (Year)

7-AGE,

29 yrs., 5 mos., 21 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

House Work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Balto. Md.

10-NAME OF FATHER,

John Mitchell

11-BIRTHPLACE OF FATHER,

(State or Country),

Balto. Md.

12-MAIDEN NAME OF MOTHER

Ida Barnes

13-BIRTHPLACE OF MOTHER,

(State or Country),

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Clarence Parsons

(Address)...

142 N. Eighth St.

15-

Filed

AUG 18 1915

ROBERT KRAUTER

Baptist Parole Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug

(Month)

(Day)

11, 1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 15 - 1915, to Aug. 17, 1915,

that I saw her alive on Aug. 17, 1915,

and that death occurred, on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH* was as follows:

John Pneumonia

(Duration)

yrs.

mos.

5 ds.

CONTRIBUTORY (Secondary)

Myocarditis

(Duration)

yrs.

mos.

2 ds.

(Signed)

Oscar O. Fairbank

M. D.

Aug. 17, 1915 (Address) St. Joseph Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

at 142 N. Eighth St.

Former or usual residence

11

11

11

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mount Carmel

Aug. 20, 1915.

20-UNDERTAKER

Lilly & Geiser

ADDRESS

403 S. Wolfe St.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *8* WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *745 N. Milton Ave* St. *16* yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Single

6-DATE OF BIRTH,

June 16, 1919
(Month) (Day) (Year)

7-AGE,

16 yrs. *2* mos. da.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housework*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Geo. Seabreeze*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore Md*

12-MAIDEN NAME OF MOTHER

*Ida Horkey*13-BIRTHPLACE OF MOTHER
(State or Country),*Australia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ida Janors*(Address) *Paradise Md*

15-

Filed

AUG 18 1915

ROBERT J. KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 3 1915, to *Aug 16* 1915,that I saw h. *2* alive on *Aug 16* 1915,and that death occurred, on the date stated above, at *7 a.* in.

The CAUSE OF DEATH* was as follows:

Diphtheria(Duration) yrs. mos. *25* ds.CONTRIBUTORY
(Secondary)(Duration) yrs. mos. *4* ds.(Signed) *Elmer H. H. H.* M. D.
8-16-15, 1915. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *12* ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? *Paradise Sta Md.*Former or usual residence *745 N. Milton Ave*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer Aug 19, 1915

20-UNDERTAKER

ADDRESS

Geo M. Fink 811 N Wolfe

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87584

104 C87584

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *710 N. Edgewood*)ST.: *10* WARD)

REGISTERED NO. C

2-FULL NAME

Robert Sullivan

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *710 N. Edgewood*)St.: *4* yrs., *3* mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

April 14, 1915
(Month) (Day) (Year)

7-AGE.

4 yrs., *3* mos., *3* ds.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore md

10-NAME OF FATHER,

Robert Sullivan

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore md

12-MAIDEN NAME OF MOTHER

Hettie Edell

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Father (Robert Sullivan)*(Address) *710 N. Edgewood*

15-

AUG 18 1915 ROBERT KRAUTER,
Filed 191. PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 17, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *August 17*, 1915, *August 17*, 1915, that I saw him alive on *August 17*, 1915, and that death occurred, on the date stated above, at *7 P. m.*

The CAUSE OF DEATH was as follows:

Cerebral Entoritis(Duration) *1* yrs., *1* mos., *1* ds.

CONTRIBUTORY (Secondary)

Convulsions(Signed) *Walter A. Meyer* M. D.*Aug 18*, 1915 (Address) *1034 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mount Olivet Cemetery *Aug 18*, 1915.

20-UNDERTAKER

ADDRESS

Henry Houch & Son *1301 E. Eager*

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2330 Etting ST.; 14 WARD)

FULL NAME

Eliza Rebecca Jones(Residence in Baltimore: No. 2330 Etting St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 52 yrs., 11 mos. 17 ds)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Female

4-COLOR OR RACE,

Colored5-SINGLE,
MARRIED,
WIDOWER,
OR DIVORCED,
(Write the word.)
Widow

6-DATE OF BIRTH,

Sept 1, 1862
(Month) (Day) (Year)

7-AGE,

52 yrs., 11 mos., 17 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Cook
Private Family9-BIRTHPLACE,
(State or Country),Balto City

10-NAME OF FATHER,

Clifton White11-BIRTHPLACE OF FATHER
(State or Country),Ind.

12-MAIDEN NAME OF MOTHER

Maria13-BIRTHPLACE OF MOTHER
(State or Country),Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. J. Keller(Address) 222 W. Monument

15-

AUG 19 1915

Filed..... 191

ROBERT KRAUTER
Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 17, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 26th 1915, to Aug 17th 1915, that I saw her alive on Aug 16th 1915, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Paralysis
Nephritis(Duration) 2 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. J. Keller M. D.Aug 17th, 1915. (Address) 222 W. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

Aug. 19, 1915

ADDRESS

102 E. Mulberry St

20-UNDERTAKER

Edwin J. Pyle

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 Mc Elday ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Emma C. Geirity(Residence in Baltimore: No. 2111 Mc Elday St.; 65 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow6. DATE OF BIRTH, Feb 11, 1817

(Month)

(Day)

(Year)

7. AGE, 98 yrs., 6 mos., 7 ds.

If LESS than 1 day, hrs. or min.?

8. OCCUPATION:

(a) Trade, profession, or particular kind of work. Housework(b) General nature of industry, business, or establishment in which employed (or employer). At Home9. BIRTHPLACE, (State or Country), Germany10. NAME OF FATHER, Gustaf Ahnemann11. BIRTHPLACE OF FATHER (State or Country), Germany12. MAIDEN NAME OF MOTHER Unkown13. BIRTHPLACE OF MOTHER (State or Country), Unkown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hans Geirity(Address) 2111 Mc Elday St.15. AUG 19 1915

Filed

ROBERT K. KRAUTER

Marital Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH, Aug 18, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20, 1915, to Aug 18, 1915, that I saw h. er alive on Dec 16, 1915, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Senile DebilityCONTRIBUTORY (Secondary) Leg ulcers(Duration) 6 yrs., 6 mos., ds.(Signed) Jacob L. Lehmann M. D.8-19-1915 (Address) 308 B. Way

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL, Baltimore CityDATE OF BURIAL, Aug 20, 1915UNDERTAKER Willard C. FullerADDRESS 224 N. Brady

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *812 S. Ann* ST.; *2* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Michael Ermatowski(Residence in Baltimore: No. *812 S. Ann* St.;yrs., mos. *24* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

July 27, 1915
(Month) (Day) (Year)

7-AGE,

20 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*none*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*Frank Ermatowski*11-BIRTHPLACE OF FATHER
(State or Country),*Russia Poland*

12-MAIDEN NAME OF MOTHER

*Anna Barran*13-BIRTHPLACE OF MOTHER
(State or Country),*Austria Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anna Ermatowski*(Address) *812 S. Ann St.*

15-

Filed

*AUG 19 1915*ROBERT J. BRAUTER,
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 18, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *August 17 1915*, to *August 17 1915*, that I saw him alive on *August 17 1915*, and that death occurred, on the date stated above, at *2 a m.* The CAUSE OF DEATH* was as follows:*Emphysema*(Duration) yrs. mos. ds. *10* ds.
CONTRIBUTORY (Secondary) *Debility 7 months*(Duration) yrs. mos. ds. *1* ds.
(Signed) *J. J. Dunbar* M. D.
August 18 1915 (Address) *722 S. Ann St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Aug. 19, 1915

20-UNDERTAKER,

William Fialkowski

ADDRESS

1618 Eastern Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87589

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624, Sheepspeare St.; 2 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1624, Sheepspeare St. St.; yrs. 7 mos. 4 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

(Month) Feb. (Day) 14, (Year) 1915

7-AGE,

yrs. 7 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

None

Infant

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Antoni Musciwyski

11-BIRTHPLACE OF FATHER (State or Country),

Russian Poland

12-MAIDEN NAME OF MOTHER

Mary Sam Kow R.

13-BIRTHPLACE OF MOTHER (State or Country),

Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antoni Musciwyski

(Address) 1624 Sheepspeare St.

15-

ROBERT J. KRAUTER,

Filed AUG 19 1915 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) Aug. (Day) 18, (Year) 1915

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 15, 1915, to Aug. 18, 1915,

that I saw her alive on Aug. 17, 1915,

and that death occurred, on the date stated above, at 10:15 m.

The CAUSE OF DEATH* was as follows:

Acute Sepsis
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. ... M. D.
3.15, 1915 (Address) 1624 Sheepspeare St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Aug. 19, 1915

20-UNDERTAKER

William T. ...

ADDRESS

1618 Eastern Ave.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1)

ST. 1

WARD

2-FULL NAME

Thomas Hopkins Hospital
Annie Beitz (Beitz)

(Residence in Baltimore: No. 515 S. Montford Avenue

St. 35 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and RH out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widowed

6-DATE OF BIRTH

June 8

1855

7-AGE

60 yrs 2 mos 8 ds

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

Germany

10-NAME OF FATHER

Christian Bolt

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Annie Bolt

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Rozzel

(Address)

John Hopkins Hospital

15-

AUG 19 1915

ROBERT . KRAUTER,

Filed

191

Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 18th

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 2nd, 1915 to August 18th 1915

that I saw her alive on August 18th 1915

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Septicemia

Post-Operative

Contributory
(SECONDARY)

Infection of the sacrum

(Duration)

yrs

mos

ds

(Signed)

Isador Gader

M. D.

August 18th 1915

[Address]

John Hopkins Hospital

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs 1 mos 17 ds. State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence 515 S. Montford Avenue

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Hill

August 21st 1915

20-UNDERTAKER

ADDRESS

H. Sander & Sons 1710 N. E. St.

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

101

Burial

Permit

Olsch

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Fracture of left hip
(Fall) (Accidental)
Fall over chair 21 ds.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Signed) Wm. J. Lockwood M. D.
117, 101A (Address) 8 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1118 Linden Ave

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

London Park Cy

Aug 20 1915

20-UNDERTAKER

ADDRESS

Stewart & Mowin Co

108 W. North Ave

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C. 18

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1)

2-FULL NAME

(Residence in Baltimore: No. 1107

Johns Hopkins Hosp
Sarah Eunitz
Columbia Ave

ST. 34 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) single

6-DATE OF BIRTH February 1915 (Month) (Day) (Year)

7-AGE If LESS than 1 day, hrs. 5 yrs. mos. ds. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE (State or country) Maryland

10-NAME OF FATHER Morris Eunitz

11-BIRTHPLACE OF FATHER (State or country) Russia

12-MAIDEN NAME OF MOTHER Dove Best

13-BIRTHPLACE OF MOTHER (State or country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A J Smith

(Address) Johns Hopkins Hosp

15-

AUG 19 1915

ROBERT KRAUTER,

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 18 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 31st, 1915, to August 18th, 1915, that I saw her alive on August 18, 1915, and that death occurred, on the date stated above, at 7:40 p.m. The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) yrs. mos. ds. 14

Contributory (SECONDARY) Peritonitis

(Duration) yrs. mos. ds. 1

(Signed) A. S. Rotholz M. D. August 18, 1915 (Address) Johns Hopkins Hosp

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. 14 In the State yrs. mos. ds. 5

Where was disease contracted, If not at place of death? at home

Former or usual residence 1107 Columbia Ave

19-PLACE OF BURIAL OR REMOVAL

Workmen circle

DATE OF BURIAL

8/19 1915

20-UNDERTAKER

Joel Lewis

ADDRESS

419 E. Pratt St

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1132 Antioke ST.) 21 WARD)

REGISTERED NO. C

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Caroline Youngham*

(Residence in Baltimore: No. 1132 Antioke

St.; 63 yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

6-DATE OF BIRTH,

June 21st, 1830
(Month) (Day) (Year)

7-AGE,

85 yrs., 1 mos., 28 da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*House Duties
At Home*

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Carl Hahle

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Elizabeth Keller

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Leiter

(Address)

1132 Antioke

15-

AUG 19 1915

ROBERT J. KRAUTER,

Filed

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 18th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*June 3 1915, to Aug 18 1915*that I saw her alive on *Aug 17 1915*and that death occurred, on the date stated above, at *4:45 p.m.*

The CAUSE OF DEATH* was as follows:

Senile Decay

(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... da.

(Signed) *Edmund J. ...* M. D.*Aug 15, 1915* (Address) *517 ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Western Cemetery**Aug 20th, 1915*

20-UNDERTAKER

ADDRESS

*Mrs John W. ...**80 W. Fayette*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 321 S Parikh ST. 19 WARD)

2-FULL NAME

Richard M Beadenkopf

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 321 S ParikhSt. 1 yrs. 1 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

July

(Month)

2, 1914

(Day)

(Year)

7-AGE

1

yrs.

1

mos.

16

ds.

or

min.?

If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)None9-BIRTHPLACE
(State or country)Baltimore

PARENTS

10-NAME OF FATHER

William C. Beadenkopf11-BIRTHPLACE OF FATHER
(State or country)Balto. Ind.

12-MAIDEN NAME OF MOTHER

Minnie O. Morgan13-BIRTHPLACE OF MOTHER
(State or country)Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William C. Beadenkopf

(Address)

321 S Parikh St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 18, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 17, 1915, to, Aug 17, 1915,that I saw him alive on Aug 17, 1915,and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Dumbness & Enteritis

(Duration)

yrs.

mos.

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

JOSE MUSE

M. D.

Aug 18, 1915 [Address] 1520 Hollis

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western CemeteryAug 20, 1915

20-UNDERTAKER

ADDRESS

Harry S. Hefke1531 E. Lombard St.

15-

AUG 19 1915

ROBERT J. KRAUTER

Marial Permit Clerk

REGISTRAR

TION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87595

HEALTH DEPARTMENT-CITY OF BALTIMORE

C87595

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1618 Baker*)

ST. *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Richard Fairfax Andersen*

(Residence in Baltimore: No. *1618 Baker*)

St. *30* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married* (Write the word)

6-DATE OF BIRTH *April 10th, 1876* (Month) (Day) (Year)

7-AGE *39* yrs. *4* mos. *6* ds. IF LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *Plumber* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Md*

10-NAME OF FATHER *Richard F. Andersen*

11-BIRTHPLACE OF FATHER (State or country) *Va*

12-MAIDEN NAME OF MOTHER *Mary Taylor*

13-BIRTHPLACE OF MOTHER (State or country) *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Kate Andersen*

(Address) *1618 Baker St*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Aug 16/15, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 1st*, 1915, to *Aug 15*, 1915, that I saw him alive on *Aug 15*, 1915, and that death occurred, on the date stated above, at *2 P.M.* The CAUSE OF DEATH* was as follows:

Paralysis (general)

Contributory (SECONDARY) *Cardiac Asthenia* (Duration) yrs. mos. ds.

(Signed) *Wm D. Buppert* M. D. (Duration) yrs. mos. ds.

8/17/15, 1915 (Address) *2106 N. Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cemetery

Aug 19, 1915

20-UNDERTAKER

ADDRESS

Christian Miller

2334 Jefferson

AUG 19 1915

ROBERT . KRAUTER,

Filed

191

Burial Permit Clerk

REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 435 N. Curley)
2-FULL NAME Irma M. Dean
(Residence in Baltimore: No. 435 N. Curley)

ST: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 1 yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single
6-DATE OF BIRTH June 18, 1914
(Month) (Day) (Year)
7-AGE 1 yrs. 2 mos. 1 ds. If LESS than 1 day, 1 hrs. or 1 min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country) Md

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ethel Dean

(Address) 435 N. Curley St

15

AUG 19 1915

ROBERT . KRAUTER, Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug. 19, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16, 1915, to Aug 19, 1915, that I saw her alive on Aug 17, 1915, and that death occurred, on the date stated above, at 1:30 p.m.
The CAUSE OF DEATH* was as follows Enteritis

Contributory

(SECONDARY)

(Signed) E. H. Meyer, Jr. M. D.

Aug 19, 1915 (Address) 111 N. Lakewood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 1 mos. 1 ds. State 1 yrs. 1 mos. 1 ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Catherine's Chapel St Mary's County Aug 19, 1915

UNDERTAKER

Christian Miller

ADDRESS

233 E. Jefferson

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.; *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Maggie Hurley*(Residence in Baltimore: No. *1422 7th Bruce St.* St.; *48* yrs., *7* mos., *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *female*4-COLOR OR RACE, *colored*5-SINGLE, *married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Jan 11, 1867*

(Month)

(Day)

(Year)

7-AGE, *48*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work, *housework*

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)?

9-BIRTHPLACE,

(State or Country), *Baltimore Md*

PARENTS.

10-NAME OF FATHER, *Frederick Freeman*11-BIRTHPLACE OF FATHER (State or Country), *Md*12-MAIDEN NAME OF MOTHER, *Lucilla Blake*13-BIRTHPLACE OF MOTHER (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert Krauth*(Address) *Orange Station Md*

15-

AUG 19 1915

Filed

ROBERT . KRAUTH

Bureau Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 18, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug. 11* 1915, to *Aug 18* 1915, that I saw her alive on *Aug 18* 1915, and that death occurred, on the date stated above, at *8 A.* m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever(Duration) yrs. mos. ds. *1*CONTRIBUTORY *Typhoid Meningitis*

(Secondary)

(Duration) yrs. mos. ds. *3*(Signed) *Overman*

M. D.

Aug 18, 1915 (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *do not know.*

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Orange Station Md*DATE OF BURIAL, *Aug 20, 1915*20-UNDERTAKER, *Sam'l. Chase & Son*ADDRESS, *1400 N. 4th St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 C87598
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1900 Edwood Place ST. 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1900 Edwood Place St. 40 yrs., 9 mos. 25 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Widower

6-DATE OF BIRTH,

(Month) Oct (Day) 24, (Year) 1874

7-AGE,

40 yrs., 9 mos., 25 ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Carpenter

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

James Parsons

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Mary E. Weaver

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Parsons(Address) 1900 Edwood Place

15-

AUG 19 1915
Filed 191 ROBERT KRAUTER
BRUNN PERMIT CLARK
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 18, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended decensed from Aug-15 1915, to Aug 18 1915, that I saw him alive on Aug 16 1915, and that death occurred, on the date stated above, at 9 45 m.

The CAUSE OF DEATH* was as follows:

Arteric Stenosis(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Dilatation of Heart 15 minutes(Signed) Blmes G. Hall M. D.Aug 19, 1915 (Address) 1617 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Ave

DATE OF BURIAL,

Aug 19, 1915

20-UNDERTAKER

John Boos

ADDRESS

104 E. N. Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 N. Glover ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 116 N. Glover St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

July 22, 1863
(Month) (Day) (Year)

7-AGE,

52 yrs., 0 mos., 27 ds.
If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Shoemaker
Self9-BIRTHPLACE,
(State or Country)Germany

10-NAME OF FATHER

Andrew Holzheid11-BIRTHPLACE OF FATHER
(State or Country)Germany

12-MAIDEN NAME OF MOTHER

Rosa Koertner13-BIRTHPLACE OF MOTHER
(State or Country)Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Maryann Holzheid
116 N. Glover St

15-

AUG 19 1915

Filed..... 191

ROBERT . KRAUTER,

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 15 1915, to Aug 15 1915,that I saw him alive on Aug 15 1915,and that death occurred, on the date stated above, at six m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis.....
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)Uremic Coma
(Duration)..... yrs..... mos..... ds.(Signed) W. Hamilton Smith M. D.Aug 15, 1915. (Address) #100 New York Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Sacred Heart Cem

DATE OF BURIAL,

Aug 19, 1915

20-UNDERTAKER

Wm. Coon

ADDRESS

3046 N. Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87600

CERTIFICATE OF DEATH.

64 C87600

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1234 Division* ST.: *17* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1234 Division*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *abt.* yrs. *70* mos. *years* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

August, *1834*
(Month) (Day) (Year)

7-AGE,

81 yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Landress*
(b) General nature of industry, business, or establishment in which employed (or employer). *Private home*

9-BIRTHPLACE, (State or Country),

Dorchester Co., Md.

10-NAME OF FATHER,

Harry Brooks

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Caroline Barnes

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Chas. J. Keller*(Address) *222 W. Thonmumet St.*

15-

AUG 19 1915 ROBERT KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August *17*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 5th* 1915, to *Aug 17th* 1915, that I saw him alive on *Aug 16th* 1915, and that death occurred, on the date stated above, at *7:40 P.m.*

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Rheumatism

(Duration) yrs. mos. ds.

(Signed) *Chas. J. Keller M. D.**Aug 17*, 1915. (Address) *222 W. Thonmumet St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Int. Auburn cemetery

DATE OF BURIAL,

August 29, 1915

20-UNDERTAKER

Geo. H. Hooper

ADDRESS

609 1/2 Pitt. Pk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 GUILFORD AVE.

REGISTERED NO. C

ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME JOHN B. MOONEY(Residence in Baltimore: No. 1108 GUILFORD AVE St.: 60 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

MALE

4-COLOR OR RACE,

WHITE

5-SINGLE, MARRIED, WIDOW, OR DIVORCED, (Write the word.) **MARRIED**

6-DATE OF BIRTH,

MARCH 15, 1884.
(Month) (Day) (Year)

7-AGE,

71 yrs. 4 mos. 30 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. RETIRED(b) General nature of industry, business, or establishment in which employed (or employer). Merchant.

9-BIRTHPLACE, (State or Country),

IRELAND

PARENTS.

10-NAME OF

FATHER, JOHN MOONEY

11-BIRTHPLACE

OF FATHER (State or Country), IRELAND

12-MAIDEN NAME

OF MOTHER MARGARET MULLEN

13-BIRTHPLACE

OF MOTHER (State or Country), IRELAND

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Mooney(Address) 1108 Guilford Ave.

15-AUG 19 1915 ROBERT . KRAUTER

Filed..... 191... Burial Permit. Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 17, 1915.
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 22 1915, to Aug 17 1915, that I saw him alive on Aug 16 1915, and that death occurred, on the date stated above, at 6:50 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration)..... yrs..... mos. 21 ds.

CONTRIBUTORY (Secondary)

(Duration) 3 yrs..... mos..... ds.(Signed) Benj. S. Hargrave M. D.Aug 18, 1915. (Address) 1216 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Landon Park Cem

DATE OF BURIAL,

8/20, 1915.

20-UNDERTAKER

Chas. P. Coates & Son

ADDRESS

1180 Mt Royal Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Pier 3, Pratt St.* ST. *22* WARD)FULL NAME *Andrew Auster*(Residence in Baltimore: No. *510 W. Lee*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*

6-DATE OF BIRTH,

unknown, 1
(Month) (Day) (Year)

7-AGE,

7 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE, (State or Country),

Balto, Md.

10-NAME OF FATHER,

William Auster

11-BIRTHPLACE OF FATHER (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Ellen Farguson

13-BIRTHPLACE OF MOTHER (State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ellen Auster*(Address) *510 W. Lee*

15-

ROBERT J. KRAUTER,

AUG 19 1915

191

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 16, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, au-topsy or inquiry.) and that said deceased came to *his* death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *James M. Savage*

(Coroner.)

Aug. 16, 1915 (Address) *1729 Madison St.*

State the DISEASE CAUSING DEATH or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

St. A...

DATE OF BURIAL,

AUG 19 1915

20-UNDERTAKER

Walter Owens

ADDRESS

318 Madison St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *17 S Carey*ST. *18* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *17 S Carey*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *40* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

unknown, *1839*
(Month) (Day) (Year)

7-AGE,

76 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE, (State or Country),

Ireland

10-NAME OF FATHER,

Braun

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Lacy*(Address) *17 S Carey St*

15-

AUG 19 1915

ROBERT . KRAUTER,

Filed *191* Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug, *17*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1915, to *Aug 16* 1915,that I saw him alive on *Aug 15* 1915,and that death occurred, on the date stated above, at *9 A* m.

The CAUSE OF DEATH* was as follows:

*Arterio Sclerosis*CONTRIBUTORY (Secondary) *Arterio Sclerosis*(Duration) *10* yrs. mos. ds.(Signed) *E. H. Houlahan* M. D.*Aug 17*, 1915 (Address) *24 H. H. Houlahan*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

Aug 20, 1915.

20-UNDERTAKER

John Houlahan, Son 901 Halling St

ADDRESS

C87604

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87604

CERTIFICATE OF DEATH.

104

PLACE OF DEATH

CITY OF BALTIMORE (No. *186 E. 28th*)2-FULL NAME *Tom G Miller*(Residence in Baltimore: No. *186 E 28th*)

REGISTERED No. C

ST. *12* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. *5* mos. *8* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Infant

6-DATE OF BIRTH,

*Mar**10th**1915*

(Month)

(Day)

(Year)

7-AGE,

*5**8*

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

*Infant*9-BIRTHPLACE,
(State or Country),*md*

10-NAME OF FATHER,

*Chas N Miller*11-BIRTHPLACE OF FATHER
(State or Country),*md*

12-MAIDEN NAME OF MOTHER

*Ada Bean*13-BIRTHPLACE OF MOTHER
(State or Country),*md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Charles H Miller

(Address)

186 E. 28th Street

15-

Filed *19* 1915

191

Chas. M. Swelaw

Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH,

*Aug**18th**1915*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest,

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

Inquest

topsy or inquiry.) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Summer's Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. M. Swelaw

(Coroner.)

M. D.

Aug 19th

1915

(Address)

423 N. Carroll St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Sanders md

DATE OF BURIAL,

Aug 20 1915

20-UNDERTAKER

Mellie Cook

ADDRESS

502 E North

Important. See instructions on back of certificate.

Joseph A Gernert,
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *12 E Gitting* ST. *23* WARD)2-FULL NAME *Joseph A. Gernert*(Residence in Baltimore: No. *12 E Gitting* St.; *46* yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widowed*
(Write the word.)6-DATE OF BIRTH. *Sept 7*, 1838

(Month)

(Day)

(Year)

7-AGE, *76* yrs., *11* mos., *10* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Retired*
(b) General nature of industry, business, or establishment in which employed (or employer). *Carpenter*9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *Jacob Gernert*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Catherine Gernert*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr J. A. Gernert*(Address) *12 E Gitting St.*

15-

Filed..... 1915

191

Chas M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 17*, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 3*, 1915, to *Aug 17*, 1915, that I saw h. *alive* on *Aug 17*, 1915, and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH* was as follows:

Infirmity of old age(Duration)..... yrs..... mos. *14* ds.CONTRIBUTORY. *Mauction*
(Secondary)(Duration)..... yrs..... mos. *7* ds.(Signed) *R. P. Campbell* M. D.*Aug 18*, 1915. (Address) *16 St. Hanover*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park Cem.*DATE OF BURIAL, *Aug 20*, 191520-UNDERTAKER *E. Schloman & Son*ADDRESS *1039 Hanover St.*

C87606

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87606

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *St Joseph's Hospital*St. *15* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

FULL NAME

William H. Burke(Residence in Baltimore: No. *1635 Westwood Ave*St. *22* yrs., *6* mos., *22* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

January 22nd, 1893
(Month) (Day) (Year)

7-AGE,

22 yrs., *6* mos., *22* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Clerk*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *md*10-NAME OF FATHER, *James E Burke*11-BIRTHPLACE OF FATHER (State or Country), *va*12-MAIDEN NAME OF MOTHER *Emma M Keppel*13-BIRTHPLACE OF MOTHER (State or Country), *md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James E Burke*(Address) *1635 Westwood Ave*

15-

AUG 19 1915

191

Chas M Judson
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 18th, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest*
(Inquest, au-topsy or inquiry.) and that said deceased came to death *on the day stated above.*

The CAUSE OF DEATH* was as follows:

(Peritonitis) Intestinal perforation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Motorcycle accident*

(Duration) yrs. mos. ds.

(Signed) *Elyah J Russell* M. D.*Aug 19th, 1915* (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE (CHIEF), state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the *44* yrs. *6* mos. *22* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1635 Westwood Ave*

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

Aug 27th, 1915

20-UNDERTAKER

Geo W Little

ADDRESS

531 N. Fremont Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 241 N Montford Ave ST. 6 WARD)

2-FULL NAME Harry Johnson

(Residence in Baltimore: No. 241 N Montford Ave St. yrs., 30 mos. ✓ day)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, Mar 21, 1883 (Month) (Day) (Year)

7-AGE, 32 yrs., 4 mos., 21 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer (b) General nature of industry, business, or establishment in which employed (or employer), General

9-BIRTHPLACE, (State or Country), MD

10-NAME OF FATHER, Thomas H Johnson

11-BIRTHPLACE OF FATHER (State or Country), MD

12-MAIDEN NAME OF MOTHER, Annie Collier

13-BIRTHPLACE OF MOTHER (State or Country), MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mable Johnson

(Address) 241 N Montford Ave

15- AUG 19 1915 Bliss

Filed 191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 17, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.)

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs., 1 mos., 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (3)

(Signed) Elyse Russell M. D.

(Coroner.) Aug 17 1915 (Address) 423 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death MD In the MD State MD yrs., 4 mos., 21 ds.

Where was disease contracted, if not at place of death? MD

Former or usual residence MD

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery DATE OF BURIAL, Aug 20, 1915

20-UNDERTAKER, Milton Davis ADDRESS 1608 N. Eldersburg St

8 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Johns Hopkins Hosp*)

ST. *5*

WARD

REGISTERED No. C. *167*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Zindel Schwartz*

(Residence in Baltimore: No. *1110 E Fayette*)

St. *5* yrs., *6* mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*

4-COLOR OR RACE, *White*

5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH, *June 1, 1915*

(Month)

(Day)

(Year)

7-AGE, *5* yrs., *6* mos., *6* ds.

If LESS than 1 day, *hrs. or min.*

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *School Boy*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *ind*

10-NAME OF FATHER, *Harry Schwartz*

11-BIRTHPLACE OF FATHER (State or Country), *Russia*

12-MAIDEN NAME OF MOTHER, *Mary Kavaney*

13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J Lewis*

(Address) *1419 E Fayette*

15-

Filed *AUG 19 1915*

101

Chas M. Sudair

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 19, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

topsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns of 2nd degree over 75% of body

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary) *Playing with matches*

(Duration)

yrs.

mos.

ds.

(Signed) *Elijah J. Russell*

(Coroner.)

M. D.

Aug 19, 1915

(Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death *5* yrs., *6* mos., *6* ds. State *5* yrs., *6* mos., *6* ds.

Where was disease contracted, if not at place of death? *at home*

Former or usual residence *1110 E. Fayette*

19-PLACE OF BURIAL OR REMOVAL, *Hebron Herrin Run*

DATE OF BURIAL, *Aug 20, 1915*

20-UNDERTAKER *Jack Lewis*

ADDRESS *1419 E Fayette*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87609

CERTIFICATE OF DEATH.

102
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 N Patterson Park ave ST.; 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1526 N Patterson Park ave St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, Married, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

July 6 th, 1879
(Month) (Day) (Year)

7-AGE.

36 yrs. 1 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Electrician
(b) General nature of industry, business, or establishment in which employed (or employer). Cons. Gas & Elec Co.

9-BIRTHPLACE, (State or Country).

Virginia

10-NAME OF FATHER.

Alfred Corron

11-BIRTHPLACE OF FATHER (State or Country).

Virginia

12-MAIDEN NAME OF MOTHER

Amanda Cameron

13-BIRTHPLACE OF MOTHER (State or Country).

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ida Corron(Address) 1526 N Patterson Park ave

15-

Filed Chas M Sinclair 1915
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 19, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 10 1915, to Aug 19 1915, that I saw him alive on Aug 18 1915, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer
Perforated
(Duration) 8 yrs. 8 mos. — ds.

CONTRIBUTORY

Peritonitis (Secondary)
(Duration) — yrs. — mos. — ds.
(Signed) John J. Dick M. D.
Aug 19, 1915. (Address) 936 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

London Park Cemetery

DATE OF BURIAL.

Aug. 21, 1915.

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E Monument

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 928 N. Vincent street, ST. 16 WARD)

FULL NAME Myrtle Kent,

(Residence in Baltimore: No. 928 N. Vincent street,

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 yrs., 9 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, November 1st, 1912. (Month) (Day) (Year)

7-AGE, 2 yrs., 9 mos., 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, William Kent,

11-BIRTHPLACE OF FATHER (State or Country), Maryland,

12-MAIDEN NAME OF MOTHER, Laura Hill,

13-BIRTHPLACE OF MOTHER (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Kent, mother,

(Address) 928 N. Vincent street.

15-

Filed 1-9-1915 191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 18th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Scald-caused by accidentally falling into a tub of boiling water, (Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Signed) J. B. Dyer, M. D. (Coroner.)

Aug. 18, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

20-UNDERTAKER, ADDRESS

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *210 McMechen* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Mary Russell Pearson(Residence in Baltimore: No. *210 McMechen*St.; *30* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

Married, widow
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

February 27, 1844
(Month) (Day) (Year)

7-AGE,

71 yrs. 5 mos. 21 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Home

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

Danvers Mass.

10-NAME OF FATHER.

Benjamin Russell

11-BIRTHPLACE OF FATHER

(State or Country).

Maine

12-MAIDEN NAME OF MOTHER

Nancy Parker

13-BIRTHPLACE OF MOTHER

(State or Country).

New Hampshire

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alice Pearson*(Address) *210 McMechen St.*

15-

Filed

1913

Chas. M. Sueland

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 18, 1913
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb 11th 1913, to *Aug 18 1913*,that I saw her alive on *Aug 18 1913*,and that death occurred, on the date stated above, at *12⁵³ P.M.*

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma
(Clinical Diagnosis + X-Ray)
(Duration) *8* yrs. *8* mos. *8* ds.

CONTRIBUTORY

(Secondary)

(Duration) *8* yrs. *8* mos. *8* ds.(Signed) *Leonard K. Beach* M. D.*Aug 14 1913* (Address) *1221 St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *8* mos. *8* ds. In the State *1* yrs. *8* mos. *8* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cemetery, Aug 20, 1913

20-UNDERTAKER

ADDRESS

Chas. G. Black 1201 W. Mulberry St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Mercy Hospital*
 CITY OF BALTIMORE (No. *St. 4* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME *Rev. Thomas E. Lyons*
 (Residence in Baltimore: No. *Mercy Hospital* St.; yrs. *2* mos. *da.*)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *single* (Write the word.)
 6-DATE OF BIRTH *March 1, 1861*
 (Month) (Day) (Year)

7-AGE, *54* yrs. *5* mos. *18* da. If LESS than 1 day,hrs. or....min.

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work... *clergyman*
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, *Baltimore Maryland*
 (State or Country),

10-NAME OF FATHER, *Thomas Lyons*

11-BIRTHPLACE OF FATHER *Ireland*
 (State or Country)

12-MAIDEN NAME OF MOTHER *Ann Quinn*

13-BIRTHPLACE OF MOTHER *Ireland*
 (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *Mrs. Mary Kelly*
 (Address) *938 E. Biddle St*

15-Filed..... 191*5* *Chas. M. Sullivan*
 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 19, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic interstitial Nephritis, General arteriosclerosis and Myocarditis.
 (Duration) *unknown* mos.da.

CONTRIBUTORY *Coronal hemorrhage* (Secondary) (Duration) *about instantly* yrs.mos.da.

(Signed) *Wm. H. Savage* M. D. (Coroner.)
Aug. 19, 1915 (Address) *1724 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs.mos.da. In the *life* State.... yrs.mos.da.

Where was disease contracted, if not at place of death?.....

Mercy Hospital
 Former or usual residence *Mercy Hospital*

19-PLACE OF BURIAL OR REMOVAL, *Cathedral Cemetery* DATE OF BURIAL, *Aug. 21, 1915*

20-UNDERTAKER *Henry W. Mason* ADDRESS *705 N. Calver St.*

important. See instructions on back of certificate.

C87613 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *2507 Madison* *apt.* *13*) WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Lillian Gilday*

(Residence in Baltimore: No. *2507 Madison* *apt.* yrs. *2* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *female* 4-COLOR OR RACE. *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *widowed* (Write the word.)

6-DATE OF BIRTH, *Sept. 23, 1882*
(Month) (Day) (Year)

7-AGE, *32* yrs. *10* mos. *24* ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *no paid occupation*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER *John T. Bailey*

11-BIRTHPLACE OF FATHER (State or Country), *Va.*

12-MAIDEN NAME OF MOTHER *Elizabeth Deaith*

13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss L. G. Gilday - sister*
(Address) *2507 Madison apt.*

15-

AUG 20 1915

101

Chas M. Snelcar
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 18, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 8* 1915, to *Aug. 18* 1915, that I saw her alive on *Aug. 17* 1915, and that death occurred, on the date stated above, at *12:20 a.m.*

The CAUSE OF DEATH* was as follows:

uterine cancer
(Operation lap. peritoneum)
(Duration) *2* yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.
(Signed) *L. F. Sherrill* M. D.
Aug. 18, 1915 (Address) *2226 Madison apt.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cemetery *Aug. 20, 1915*

20-UNDERTAKER

ADDRESS

Henry W. Mawhlon *805 N. Calver*

C87614

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87614

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1935 Bunt St. 15 WARD)2-FULL NAME Mary Johnson(Residence in Baltimore: No. 1935 Bunt St. 14 yrs. 1 mos. 1 ds.)REGISTERED NO. C. 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX 7 4-COLOR OR RACE C 5-SINGLE MARRIED WIDOWED OR DIVORCED Widowed (Write the word)6-DATE OF BIRTH Don't know (Month) 1 (Day) (Year)7-AGE 50 yrs. 1 mos. 1 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Private Family

9-BIRTHPLACE (State or country)

Eastern Shore Md.

10-NAME OF FATHER

Aaron Kirby

11-BIRTHPLACE OF FATHER (State or country)

Eastern Shore Md.

12-MAIDEN NAME OF MOTHER

Elizabeth Sullivan

13-BIRTHPLACE OF MOTHER (State or country)

Eastern Shore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ethel Butler(Address) 1935 Bunt St

15-

AUG 20 1915

Chas M. Sullivan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 18, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 18, 1915, to Aug 18, 1915,that I saw her alive on Aug 18, 1915,and that death occurred, on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 6 yrs. 6 mos. 1 ds.

Contributory (SECONDARY)

(Duration) 2 yrs. 1 mos. 1 ds.(Signed) Chas M. Sullivan M. D.Aug 18, 1915 [Address] 1209 Bunt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1209 Bunt St

19-PLACE OF BURIAL OR REMOVAL

Mount Auburn

DATE OF BURIAL

August 20, 1915

20-UNDERTAKER

John H. Owen

ADDRESS

1222 Bunt St

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 3403 Clifton Ave

ST. 15 WARD)

2-FULL NAME Mrs Mary J. D. Koch

(Residence in Baltimore: No. 3403 Clifton Ave

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female
4-COLOR OR RACE White
5-SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word)
6-DATE OF BIRTH June 4th, 1844
(Month) (Day) (Year)
7-AGE 71 yrs. 2 mos. 13 ds. or min. 7

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE (State or country)

Balto.

10-NAME OF FATHER

Chas. Spilker

11-BIRTHPLACE OF FATHER (State or country)

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. Koch

(Address)

3403 Clifton Ave

AUG 20 1915

Filed

Chas M Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 17th, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1915, to Aug. 17, 1915, that I saw her alive on Aug. 17, 1915, and that death occurred, on the date stated above, at 7:15 P. m. The CAUSE OF DEATH* was as follows:

Angina Pectoris
(Myocarditis?)

Contributory (SECONDARY)

(Duration) 1 yrs. mos. ds.

Mitral insufficiency

(Signed)

Aug. 18, 1915 (Address) 3101 Clifton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park

Aug. 20, 1915

20-UNDERTAKER

ADDRESS

E. M. Mitchell & Co. 201 W. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,

WIDOW,

OR DIVORCED.

(Write the word)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15

AUG 20 1915

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Duration)

(Signed)

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER.

ADDRESS

C87617

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87617

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *621 N Central Ave* ST.: *5* WARD)

REGISTERED NO. C

2-FULL NAME

Ebene Johnson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *621 N Central Ave*

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Colored*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Widowed*

6-DATE OF BIRTH,

Unknown, *1*.....
(Month) (Day) (Year)

7-AGE,

2

yrs. mos. ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*Domestic*9-BIRTHPLACE,
(State or Country),*Ind*

10-NAME OF FATHER,

*Joseph Waters*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Nellie Cooper*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William Johnson

(Address)

621 N Central Ave

15-

AUG 20 1915

Filed.....

191

Chas M. Sinclair

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug, *19*, *1915*
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*
(Inquest, au-topsy or inquiry.) and that said deceased came to *death*
on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Elyah J. Russell* M. D.*Aug 19*, 1915 (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Asbury

DATE OF BURIAL,

Aug 22 1915

20-UNDERTAKER

John W Henderson

ADDRESS

317 Caroline

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *608 Madenia* ST.: *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Baby Thompson*(Residence in Baltimore: No. *608 Madenia* St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *Black* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *August 16, 1915*
(Month) (Day) (Year)7-AGE, *14* yrs. mos. ds. If LESS than 1 day, hrs. or min. *14*8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Infant*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Samuel Thompson*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Agnes Hansen*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Raymond G. Gellish*(Address) *Johns Hopkins Hospital*15- *AUG 20 1915* *Chas M. Sinclair*
Filed. 1915 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 16, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 16, 1915*, to *Aug 16, 1915*, that I saw her alive on *Aug 16, 1915*, and that death occurred, on the date stated above, at *3 30* m.The CAUSE OF DEATH* was as follows:
Pneumonia
Septic
Septicemia
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *Wm. J. Muller* M. D. *Aug 16, 1915* (Address) *Johns Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or present residence

19-PLACE OF BURIAL OR REMOVAL, *JOHNS HOPKINS HOSPITAL*DATE OF BURIAL, *AUG. 19, 1915*20-UNDERTAKER *Commissioner Health.* ADDRESS

FOR ANATOMICAL PURPOSES

C87619 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *616 Madenia* ST.: *7* WARD)2-FULL NAME *Baby Ford*(Residence in Baltimore: No. *1616 Madenia*37
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; ... yrs. ... mos. ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female Black

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)

6-DATE OF BIRTH.

August 16, 1915
(Month) (Day) (Year)

7-AGE.

If LESS than 1 day.

... yrs. ... mos. ... da.

9 hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE.

(State or Country).

Maryland

10-NAME OF FATHER.

James Ford

11-BIRTHPLACE OF FATHER.

(State or Country).

Maryland

12-MAIDEN NAME OF MOTHER.

Maggie Williams

13-BIRTHPLACE OF MOTHER.

(State or Country).

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Raymond Sells

(Address).

Johns Hopkins Hospital

15-

AUG 20 1915

Filed.

191

Chas M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 16 1915 to *Aug 16 1915*that I saw her alive on *Aug 16 1915*and that death occurred, on the date stated above, at *7 P. M.*

The CAUSE OF DEATH* was as follows:

*Pneumonia by Sepsis**Septic**Septic*

(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

None

(Duration) ... yrs. ... mos. ... da.

(Signed)

Wm. L. Miller M. D.
Aug 16, 1915 (Address) *Johns Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL.

AUG 19 1915

20-UNDERTAKER

Commissioner Health.

ADDRESS

FOR ANATOMICAL PURPOSES.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87620 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH *John March,*

CITY OF BALTIMORE (No. *1438 Woodall* ST. *24* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John March*

(Residence in Baltimore: No. *1438 Woodall St* St. *17* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married* (Write the word)

6-DATE OF BIRTH *Aug 18, 1859* (Month) (Day) (Year)

7-AGE *56* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *Care taken of* (b) General nature of industry, business, or establishment in which employed (or employer) *Blow Stone*

9-BIRTHPLACE (State or country) *Ga*

PARENTS

10-NAME OF FATHER *Unknown*

11-BIRTHPLACE OF FATHER (State or country) *Unknown*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or country) *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *John T. March*

(Address) *1438 Woodall St*

15. *Chas M Sinclair*

Filed *AUG 20 1915* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Aug 18, 1915* (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 1, 1915*, to *Aug 17, 1915*, that I saw him alive on *Aug 17, 1915*, and that death occurred, on the date stated above, at *6 a m.*

The CAUSE OF DEATH* was as follows:
Tuberculosis, heart ribs
arterio sclerosis
fell on ice on pavement

(Duration) yrs. *6* mos. ds.

Contributory (SECONDARY) *Diphtheria*

(Duration) yrs. mos. *7* ds.

(Signed) *C. H. Hutchins* M. D.

Aug 18, 1915 (Address) *1130 Light St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Edgar Hill Cem* DATE OF BURIAL *Aug 24, 1915*

20-UNDERTAKER *M. J. E. Evanson* ADDRESS *1428 Charles St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 N. Montford Ave. WARD)

REGISTERED NO. C

2-FULL NAME Frederick J. Pross

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1414 N. Montford Ave. St. 24 yrs. 24 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 14, 1891
(Month) (Day) (Year)

7-AGE, 24 yrs. 3 mos. 4 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), City

10-NAME OF FATHER, Julius Pross

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Bertha

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matilda Pross

(Address) 1414 N. Montford

15- Aug. 20 1915 Geo. M. Sinclair

Filed 20 1915 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 15, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1915, to Aug 18 1915,

that I saw h. — alive on Aug 18 1915 and that death occurred, on the date stated above, at 745A m.

The CAUSE OF DEATH* was as follows:

Enteric Fever

(Duration)..... yrs. mos. 13 ds.

CONTRIBUTORY Intestinal Hemorrhage
(Secondary)

(Duration)..... yrs. mos. 3 ds.

(Signed) Dr. J. B. Brown M. D.

Aug 15, 1915. (Address) 25 E. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cem DATE OF BURIAL, Aug 20 1915

20-UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *1123 Biscot* St. *21* WARD)2-FULL NAME *May E. Grayson*

(If death occurred in a hospital or institution, give its NAME instead of street and number, and fill out No. 18.)

(Residence in Baltimore: No. *1123 Biscot* St. *Lifetime* yrs. *0* mos. *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

March

(Month)

(Day)

(Year)

7-AGE

about 38

yrs.

mos.

ds.

or

min.?

If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Domestic**at home*

9-BIRTHPLACE

(State or country)

Baltimore

10-NAME OF FATHER

Lincoln Codge

11-BIRTHPLACE OF FATHER

(State or country)

md

12-MAIDEN NAME OF MOTHER

Annie Johnson

13-BIRTHPLACE OF MOTHER

(State or country)

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Grayson

(Address)

1123 Biscot St

15-

Filed

191

Chas M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*Aug 18**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Aug 17, 1915**to**Aug 18**1915*

that I saw her alive on

*Aug 17**1915*and that death occurred, on the date stated above, at *2:30 p* m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Contributory (SECONDARY)

Uraemia (coma)

(Signed)

E. S. Ellis

[Address]

915 Light St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

in the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt. Auburn St

DATE OF BURIAL

Aug 21, 1915

20-UNDERTAKER

J. L. Brown & Son

ADDRESS

108 N. Maryland St

TION is very important. See instructions on back of certificate.

C87623

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *213 S High* ST.; *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *213 S High* St.; *25* yrs., *—* mos. *—* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

Unknown, *1* (Month) (Day) (Year)

7-AGE,

80 yrs. *—* mos. *—* da.If LESS than 1 day, *—* hrs. or *—* min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Nathan Rosenfeld*(Address) *213 S High st*

15-

Filed *AUG 20 1915**Chas. McClair*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

8 - 20, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *5-17-* 191*5*, to *8-16-* 191*5*, that I saw him alive on *8-16-* 191*5*, and that death occurred, on the date stated above, at *4:30 a* m.

The CAUSE OF DEATH* was as follows:

*Carcinoma of Stomach**(no microscopic exam.)*(Duration) *9* yrs. *9* mos. *—* da.

CONTRIBUTORY (Secondary)

(Duration) *—* yrs. *—* mos. *—* da.(Signed) *C. O'Brien* M. D.*8/20*, 191*5* (Address) *116 S. High st*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *—* da. In the *—* State *—* yrs. *—* mos. *—* da.

Where was disease contracted, if not at place of death?

Former or usual residence *213 S High st*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Rosedale Cemetery *Aug 20 1915*

20-UNDERTAKER

ADDRESS *1107 E**S. Linscott Bro Balto st*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2043 E. Fairmount Ave WARD) 6

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James De Witt Boyman(Residence in Baltimore: No. 2043 E. Fairmount Ave St.; 10 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word.)6-DATE OF BIRTH, Feb 3, 1886
(Month) (Day) (Year)7-AGE, 29 yrs., 6 mos., 14 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Motorman
(b) General nature of industry, business, or establishment in which employed (or employer). P. R. R.9-BIRTHPLACE,
(State or Country), Md.10-NAME OF FATHER Alfred R. Boyman11-BIRTHPLACE OF FATHER (State or Country), Md.12-MAIDEN NAME OF MOTHER Sarah Wilson13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary R. Boyman(Address) 2043 E. Fairmount Ave

15-

Filed..... 1915

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 19, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY That I attended deceased from Oct 1 1914, to Aug 19 1915,
that I saw him alive on Aug 12 1915,
and that death occurred, on the date stated above, at 9:45 A. M.

The CAUSE OF DEATH* was as follows:

L. A. Phthisis(Duration) 11 yrs., 11 mos., ds.CONTRIBUTORY (Secondary) Phthisis(Duration) 1 yrs., 1 mos., ds.(Signed) G. C. Cade M. D.120, 1915. (Address) 1437 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Calvary Cemetery, Oct 1, 1915.20-UNDERTAKER ADDRESS Alfred E. Fuller, 221 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1700 E. B. St.* ST. *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Bessie Hender*(Residence in Baltimore: No. *1700 E. B. St.* St. *13* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-STATUS
MARRIED, *Widowed*
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH *Aug* (Month) *18* (Day) *1899* (Year)7-AGE *16* yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Russia*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Russia*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Heur's*(Address) *1419 E. B. St.*

15-

AUG 20 1915

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Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August* (Month) *20* (Day) *1915* (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug. 16* 1915, to *Aug. 20* 1915, that I saw her alive on *Aug. 20* 1915, and that death occurred, on the date stated above, at *11:30* m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis,(Duration) *not known* yrs. mos. ds.CONTRIBUTORY... *Arterio-sclerosis* (Secondary)(Duration) *not known* yrs. mos. ds.(Signed) *Herman Seidel* M. D.*Aug. 20, 1915* (Address) *1523 E. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Heavenly Haven Rm*DATE OF BURIAL, *Aug. 20, 1915*20-UNDERTAKER *Jack Lewis*ADDRESS *1419 E. B. St.*

C87626

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87626

CERTIFICATE OF DEATH.

159

PLACE OF DEATH

CITY OF BALTIMORE (No.

St. Joseph's Hospital

ST:

8

WARD)

REGISTERED NO. C

2-FULL NAME

Joseph Munday

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1908 N Chester

St.; yrs. 23 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word.)

Married

6-DATE OF BIRTH,

May

11th

1892

(Month)

(Day)

(Year)

7-AGE,

23

yrs.

2

mos.

29

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Printer

9-BIRTHPLACE,
(State or Country).

Md

10-NAME OF FATHER,

Joseph Munday

11-BIRTHPLACE OF FATHER
(State or Country)

Md

12-MAIDEN NAME OF MOTHER

Went Krum

13-BIRTHPLACE OF MOTHER
(State or Country).

Went Krum

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Pauline C. Munday

(Address)

1908 N. Chester

15-

Filed

AUG 20 1915

Geo W. Suelzer

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug

18

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquest, autopsy or inquiry.)

And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

(Suicide) Pistol shot wound in right temple

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Elijah J. Russell

(Coroner.)

M. D.

Aug 20th 1915 (Address) 423 N. Broadway

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State 23 yrs. 2 mos. 29 ds.

Where was disease contracted, if not at place of death?

1908 N. Chester

Former or usual residence 1908 N. Chester

19-PLACE OF BURIAL OR REMOVAL

Oaklawn Cem

DATE OF BURIAL

Aug 17, 1915

20-UNDERTAKER

Wm. Cook

ADDRESS

581 E. N. Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

ROBERT . KRAUTER,

Burial Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from
that I saw her alive on
and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Alimentary Decomposition
(None before admission)CONTRIBUTORY
(Secondary)

(Signed)

Aug. 19, 1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 6 mos. 17 ds. In the State yrs. 6 mos. 14 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

COLLEGE OF P. & S.

DATE OF BURIAL,

AUG. 20, 1915

20-UNDERTAKER

Commissioner Health

ADDRESS

FOR ANATOMICAL PURPOSES.

C87628

HEALTH DEPARTMENT--CITY OF BALTIMORE

PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 3029 Cedar Ave.,

ST. 13 WARD)

2-FULL NAME Infant daughter of Arthur & Ada Hatfield

(Residence in Baltimore: No. 3029 Cedar Ave.,

St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OF RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

Aug

20, 1915

(Month)

(Day)

(Year)

7 AGE

yrs.

mos.

ds.

If LESS than 1 day 2 hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE

(State or country)

Balto City

10 NAME OF FATHER

Arthur Hatfield

11 BIRTHPLACE OF FATHER

(State or country)

Carroll Co

12 MAIDEN NAME OF MOTHER

Ada D. Hatfield

13 BIRTHPLACE OF MOTHER

(State or country)

Balto City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur Hatfield

(Address)

3029 Cedar Ave

15

AUG 21 1915

ROBERT

KRAUTER,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August

20, 1915/91

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/20/15, 191, to, 3/20/15, 191

that I saw her alive on August 20, 1915/91 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) A. J. Davies M. D.

8/20/15, 191 (Address) 200 W. 33rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

104
CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1908 Bank St. St. 2 WARD)2-FULL NAME Kazmira Milosek

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1908 Bank St. St.; yrs. 6 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Dec251914

(Month)

(Day)

(Year)

7-AGE

625

ds.

If LESS than

1 day,

hrs.,

or

min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

NoneInfant

9-BIRTHPLACE

(State or country)

Baltimore

10-NAME OF FATHER

Stanislaw Milosek

11-BIRTHPLACE OF FATHER

(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Helena Grunciewicz

13-BIRTHPLACE OF MOTHER

(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Stanislaw Milosek

(Address)

1908 Bank St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 20th1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

August 8th, 1915, to, August 20th, 1915,that I saw her alive on August 10th, 1915,and that death occurred, on the date stated above, at 4:15 m.

The CAUSE OF DEATH* was as follows:

Chorea Infantum

(Duration)

yrs

mos

ds.

Contributory
(SECONDARY)

(Duration)

yrs

mos

ds.

(Signed),

R. D. Smith

M. D.

Aug 20, 1915

[Address]

1902 Bank St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death

yrs

mos

ds.

In the

yrs

mos

ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy RosaryAug 211915

20-UNDERTAKER

ADDRESS

Jacob Gvalkowski428 S. Bond St.

15 AUG 21 1915

Filed

191

ROBERT . KRAUTER,

Burial Permit Officer

REGISTRAR

TION is very important. See instructions on back of certificate.

C87630 HEALTH DEPARTMENT—CITY OF BALTIMORE C87630

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1910. Canton Ave. ST.; 2 WARD)

2. FULL NAME

(Residence in Baltimore: No. 1910. Canton Ave. St.; 23 yrs., 11 mos. 30 ds.)79
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOW

OR DIVORCED

(Write the word.)

Single

6-DATE OF BIRTH

Aug 19, 1891
(Month) (Day) (Year)

7-AGE

23 yrs., 11 mos., 30 ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Laborer
General9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

John Nowak.

11-BIRTHPLACE OF FATHER
(State or Country),

Germany.

12-MAIDEN NAME OF MOTHER

Agnes Nowak.

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Nowak.

(Address)

1910. Canton Ave.

AUG 21 1915

ROBERT . KRAUTER

Filed

191

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 18, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

August 13, 1915, to August 18, 1915,

that I saw him alive on August 18, 1915,

and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Mental degeneration, chronic
compensation, acute diffuse nephritis
(Duration) 1 yrs., 11 mos., 30 ds.CONTRIBUTORY... Arteriosclerosis & Heart failure
(Secondary)

(Duration) 2 yrs., 11 mos., 30 ds.

(Signed) J. Henry A. O'Rourke M. D.

8/18, 1915. (Address) 126 Jackson Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Aug 21, 1915.

20-UNDERTAKER

William Fialkowski, 1618 Eastern Ave.

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87631

54 C87631

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2000 for the Home of Maryland* ST.;..... WARD) *4*FULL NAME *Mrs Helen R. Brown*Residence in Baltimore: No. *115 W. Mulberry St.* St.; *25* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)

6-DATE OF BIRTH, *July 20, 1867*
(Month) (Day) (Year)

7-AGE, *48* yrs. *1* mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country), *New York*

PARENTS.
10-NAME OF FATHER, *unknown*
11-BIRTHPLACE OF FATHER (State or Country), *unknown*
12-MAIDEN NAME OF MOTHER *Wilkes*
13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *May G. Litchford*(Address) *Woman's Hosp*

15- AUG 21 1915 ROBERT . KRAUTER,
Filed. Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 19, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug - 6 1915* to *Aug - 19 1915*,
that I saw her alive on *Aug 19 1915*,
and that death occurred, on the date stated above, at *11:00 P.m.*

The CAUSE OF DEATH* was as follows:

Pericardial Anemia
.....
..... (Duration) *1* yrs. mos. ds.

CONTRIBUTORY
(Secondary).....

(Signed) *A. P. Jones* M. D.
Aug 19, 1915 (Address) *W. Deans Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *13* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *115 W. Mulberry St.*

19-PLACE OF BURIAL OR REMOVAL,

Louisa Park

DATE OF BURIAL,

Aug 22, 1915

20-UNDERTAKER

H. Breunig, Soc

ADDRESS

517 N. Schneider St.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. *1927 E. Fairmount Ave.* ST. *6* WARD)2-FULL NAME *Elba M. Smith*(Residence in Baltimore: No. *1927 E. Fairmount Ave.* St.; *Life* yrs. *6* mos. *4* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*Single*

6-DATE OF BIRTH

*June 9**1915*

7-AGE

*2 11*If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE
(State or country)*Md Balto.*

10-NAME OF FATHER

*John W. Smith*11-BIRTHPLACE OF FATHER
(State or country)*Md*

12-MAIDEN NAME OF MOTHER

*Elizabeth Miller*13-BIRTHPLACE OF MOTHER
(State or country)*Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John W. Smith

(Address)

1927 E. Fairmount Ave.

15-

AUG 21 1915

ROBERT KRAUTER,
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug. 20, 1915

17- I HEREBY CERTIFY, That I attended deceased from

Aug 19, 1915, to, *Aug 20, 1915*that I saw him alive on *Aug 19, 1915*, and that death occurred, on the date stated above, at *5 am.*

The CAUSE OF DEATH* was as follows:

*Intestinal Rickets*Contributory
(SECONDARY)

(Signed)

John W. Smith M.D.
1915 [Address] *14376 18th*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Cemetery

DATE OF BURIAL

Aug 21, 1915

20-UNDERTAKER

Christian Miller 2334 Jefferson St.

TION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

87633
PLACE OF DEATH
CITY OF BALTIMORE (No. 627 E 28th St ST. 9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Charles Mitchell
(Residence in Baltimore: No. 627 E 28th St St. 1 yrs. 6 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Colored 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)
6-DATE OF BIRTH Unknown, 1914 (Month) (Day) (Year)
7-AGE Chart 1 yrs. 6 mos. 6 ds. or min. ? If LESS than 1 day, hrs.
8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
9 BIRTHPLACE (State or country) Balto
PARENTS
10 NAME OF FATHER Harold A. Mitchell
11 BIRTHPLACE OF FATHER (State or country) Balto
12 MAIDEN NAME OF MOTHER Henrietta Webb
13 BIRTHPLACE OF MOTHER (State or country) Balto

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henrietta Webb
627 E 28th St.
(Address)

15- AUG 21 1915 Chas. W. Sinclair
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug. 19th, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18, 1915 to Aug 19th, 1915 that I saw him alive on Aug 18th, 1915 and that death occurred, on the date stated above, at 2:15 Pm.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Indefinite (Duration) yrs. mos. ds.
Contributory Bronchitis acuta
(SECONDARY) Indefinite (Duration) yrs. mos. ds.
(Signed) J. Albert Miller M. D.
8-19-1915 (Address) 2723 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Urbary

Aug 21st, 1915

20-UNDERTAKER

ADDRESS

Wm J. Jackson 1409 Mauldin St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 Montgomery ST.; 22 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 602 W. Montgomery St. 22 yrs. 5 mos. 10 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE

col5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) married

6-DATE OF BIRTH

April 24, 1860.
(Month) (Day) (Year)

7-AGE

25 yrs. 5 mos. 10 da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Labrer
General

9-BIRTHPLACE, (State or Country),

Batts Md

10-NAME OF FATHER,

Allen Holmes

11-BIRTHPLACE OF FATHER

(State or Country),

W.D.

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Holmes(Address) 602 W. Montgomery

15-

Filed

21 1915

191

Chas. M. Mullan

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 19, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 14 1915, to Aug 14 1915;that I saw him alive on Aug 14 1915;and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....

..... (Duration) yrs. 4 mos. 10 da.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. 1 mos. 10 da.(Signed) S. H. Brown M. D.Aug 20, 1915. (Address) 522 W. Montgomery

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 5 mos. 10 da. In the State yrs. 5 mos. 10 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

mt. Auburn ct Aug 22, 1915.

20-UNDERTAKER

ADDRESS

J. H. Brown 108 W. Montg

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87635

C87635

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *819 Leaden hall* ST. *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *William A Carr*(Residence in Baltimore: No. *819 Leaden hall* St. *40* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) *Widowed*

6-DATE OF BIRTH,

unknown, 18*64*
(Month) (Day) (Year)

7-AGE,

51 yrs. mos. ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),*md*

10-NAME OF FATHER,

*Charles Carr*11-BIRTHPLACE OF FATHER
(State or Country),*md*

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louisa Robinson*(Address) *819 Leaden hall*

15-

Filed

191

Chas M. McClure

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 20, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 1, 1915*, to *Aug 20, 1915*, that I saw him alive on *Aug 18, 1915*, and that death occurred, on the date stated above, at *1:30* p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(Duration) *1* yrs. mos. ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. mos. ds.(Signed) *A. M. Carr**8/20, 1915* (Address) *2005 Arden St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

mt. Auburn *Aug 22, 1915*

20-UNDERTAKER

ADDRESS

J. L. Thompson *108 W. Mount St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2621 Sloatfield* ST.; *20* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *William B. E. Hoover*(Residence in Baltimore: No. *2621 Sloatfield* St.; yrs. *4* mos. *13* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, *Single*
 6-DATE OF BIRTH. *April 7, 1915*
 (Month) (Day) (Year)
 7-AGE. *4 yrs. 13 mos.* If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Child*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore City*

10-NAME OF FATHER. *John B. Hoover*
 11-BIRTHPLACE OF FATHER (State or Country). *Indiana*
 12-MAIDEN NAME OF MOTHER. *Lela Clark*
 13-BIRTHPLACE OF MOTHER (State or Country). *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John B. Hoover*
 (Address) *2621 Sloatfield*

15-*AUG 21 1915*
 Filed *Wm. H. H. H. H.*
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *August 19, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 19* 1915, to *Aug. 19* 1915, that I saw him alive on *August 14* 1915, and that death occurred, on the date stated above, at *10:30 a.m.*

The CAUSE OF DEATH* was as follows:
Chronic Intestinal Indigestion
Chronic Malnutrition
 (Duration).....yrs. *4* mos. *13* ds.

CONTRIBUTORY *Acute Intest. Intoxication*
 (Secondary) *24 hours*

(Signed) *H. Carroll Lockard* M. D.
Aug. 20, 1915. (Address) *46 Preston St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *London Park* DATE OF BURIAL, *Aug. 22, 1915.*

20-UNDERTAKER *William Cook* ADDRESS *502 E. North Ave.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 S. Arlington ST.; 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 9 S. Arlington St.; 18 yrs., 2 mos., 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIEDMarriedWIDOWED,OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

June 11, 1844
(Month) (Day) (Year)

7-AGE,

71 2 9
yrs. mos. ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Stone Cuts9-BIRTHPLACE,
(State or Country),Germany

10-NAME OF FATHER,

Unknown11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Dr. M. Schwartz
924 Edmondson

15-

Filed

AUG 21 1915

191

Chas M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 19, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 1914, to Aug 18 1915that I saw him alive on Aug 19 1915and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral IncompetenceIndefinite
(Duration) yrs. mos. ds.CONTRIBUTORY.
(Secondary)Acute Dilatation
(Duration) yrs. mos. ds.(Signed) R. H. Casper M. D.Aug 19, 1915 (Address) 1644 Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Bowdon Park Cemetery Aug 23 1915

20-UNDERTAKER

ADDRESS

George J. Smith 1240 N. 1st St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *231 N. Gilman* ST. *19* WARD)

2-FULL NAME *William F. Marriott*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *231 N. Gilman* St. yrs. *6* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-~~SINGLE~~ ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ *Widower*
(Write the word)

6-DATE OF BIRTH *Aug 3, 1826*
(Month) (Day) (Year)

7-AGE *89* yrs. *18* mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *Wagon Builder*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Ellisport City Md.*

PARENTS 10-NAME OF FATHER *Wm Marriott*
11-BIRTHPLACE OF FATHER *Md.*
12-MAIDEN NAME OF MOTHER *Jane Smith*
13-BIRTHPLACE OF MOTHER *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Wm E. Marriott*
(Address) *231 N. Gilman*

FILED *AUG 21 1915* 191 *Geo W. McClure*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Aug 20, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 2, 1915*, to *Aug 20, 1915*, that I saw him alive on *Aug 19, 1915*, and that death occurred, on the date stated above, at *3:50 P. m.* The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
(Duration) *3* yrs. *18* mos. ds.
Contributory (SECONDARY) *Coronary Artery*
(Duration) *18* yrs. *18* mos. ds.
(Signed) *J. L. Cooper* M. D.
Aug 21, 1915 (Address) *912 W. Fayette St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *W. B. Line Cemetery* DATE OF BURIAL *Aug 23, 1915*
20-UNDERTAKER *George J. Smith* ADDRESS *Hyattsville*

C87639

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87639

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *1619 N. Castle* ST.: *8* WARD)2-FULL NAME *Margaret Jones*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No. *1619 N. Castle* St.; *30* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *F.*4-COLOR OR RACE *W.*

5-SINGLE

MARRIED

WIDOWED

OR SEPARATED

(Write the word) *Widowed*

6-DATE OF BIRTH

*July 23**1843*

(Month)

(Day)

(Year)

7-AGE

72 yrs. mos. ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Housewife*9-BIRTHPLACE
(State or country)*Ireland*

10-NAME OF FATHER

*William O'neal*11-BIRTHPLACE OF FATHER
(State or country)*Ireland*

12-MAIDEN NAME OF MOTHER

*Margaret*13-BIRTHPLACE OF MOTHER
(State or country)*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Jones

(Address)

1619 N. Castle

15-

Filed

191

Geo M Sinclair
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*Aug 19**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 14, 191*5*, to, *Aug 19*, 191*5*that I saw her alive on *Aug 18*, 191*5*and that death occurred, on the date stated above, at *28* m.

The CAUSE OF DEATH* was as follows:

*Cardiac disease
Myocarditis*Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed),

August 16 1915 [Address] *1419 E. Bay St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

New Cashed Cemetery

DATE OF BURIAL

Aug 23, 191*5*

20-UNDERTAKER

George A. Ruth

ADDRESS

1735 Norfolk

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *1336 Argyle Ave* ST.; WARD)2-FULL NAME *Isaiah Raiff*(Residence in Baltimore: No. *1336 Argyle Ave* St.; *45* yrs., *—* mos. *—* ds.)REGISTERED NO. C *120 C87640*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE, *Colored*5-SINGLE, *Married*,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Unknown, 1870*

(Month)

(Day)

(Year)

7-AGE *45* — yrs. — mos. — ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Labourer*(b) General nature of industry, business, or establishment in which employed (or employer) *General*9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Isaiah Raiff*11-BIRTHPLACE OF FATHER (State or Country), *md*12-MAIDEN NAME OF MOTHER *Susan Wesley*13-BIRTHPLACE OF MOTHER (State or Country), *md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anna Raiff*(Address) *1336 Argyle Ave*

15-

Filed *5161* *18* *30* 191 *11* *11* *11*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 18, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 16* 191 *5*, to *August 18* 191 *5*,
that I saw him live on *August 18* 191 *5*,
and that death occurred, on the date stated above, at *30* p m.

The CAUSE OF DEATH* was as follows:

Bright's disease

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary) *Heart & Kidney*

Disease

(Duration)

yrs.

mos.

ds.

(Signed) *Dr. W. H. Henshaw* M. D.*August 18* 191 *5* (Address) *708 Enoch St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Lawrence*DATE OF BURIAL, *Aug 21, 1915*20-UNDERTAKER *Alfred J. Henshaw*ADDRESS *114 N. Schroder*

C87611

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87611

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *University Md Hosp* St.: *4* WARD)2-FULL NAME *William W. Mitten*(Residence in Baltimore: No. *Westminster Md* St.: yrs., *10* mos. ds.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Aug 24, 1881
(Month) (Day) (Year)

7-AGE,

64 yrs. 11 mos. 22 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Butcher

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*William Mitten*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Mary Delphy*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *W. H. Mitten*(Address) *Westminster Md*

15-

AUG 21 1915

Chas M. Suelzer

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 20, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquiry*
(Inquest, au-topsy or inquiry.) and that said deceased came to *his* death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Aspiratory Pneumonia
(Suicide)

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Knife wound of throat*(Signed) *J. J. Jeffers*

(Coroner.)

M. D.

191... (Address) *413 N. Carrollton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death... yrs. mos. *7 mos* In the *64* ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

*Westminster Md*Former or usual residence *Westminster Md*

19-PLACE OF BURIAL OR REMOVAL,

Westminster Md

DATE OF BURIAL,

Aug 21, 1915

20-UNDERTAKER

H. Bauckard & Son Westminster Md

ADDRESS

Important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Protestant Hospital

REGISTERED NO. C.

CITY OF BALTIMORE: (No.

413 W Biddle

ST.

WARD)

2-FULL NAME

Richard Taylor

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

(Residence in Baltimore: No.

305 W. Biddle

St.; 60

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

Unknown

1838

7-AGE

77

yrs.

mos.

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Carpenter

9-BIRTHPLACE

(State or country)

Maryland

10-NAME OF FATHER

Unknown

11-BIRTHPLACE

OF FATHER

(State or country)

Unknown

12-MAIDEN NAME

OF MOTHER

Unknown

13-BIRTHPLACE

OF MOTHER

(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. Bernard Taylor

(Address)

305 W Biddle St

15-

Filed

1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

August 19, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

Aug 18, 1915, to, Aug 19, 1915

that I saw him alive on Aug 19, 1915

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

General Arterio-Sclerosis

(Duration)

5

yrs.

mos.

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

H. M. Card

M. D.

Aug 19, 1915

[Address]

305 W Biddle St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place

of death

yrs.

mos.

In the

60

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

305 W Biddle St

Former or

usual residence

305 W Biddle St

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Auburn

8/21

1915

20-UNDERTAKER

ADDRESS

Sweet's Undertakers 78 W Biddle St

C87643 HEALTH DEPARTMENT—CITY OF BALTIMORE

C87643

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 E Monument ST. 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2112 E Monument St. 30 yrs., 0 mos., 00 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

Feb 3, 1865
(Month) (Day) (Year)

7-AGE,

50 yrs., 6 mos., 18 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Kellogg Keeper

9-BIRTHPLACE, (State or Country),

Bohemia

10-NAME OF FATHER,

John Pospisil

11-BIRTHPLACE OF FATHER (State or Country),

Bohemia

12-MAIDEN NAME OF MOTHER

Barbara Shulsal

13-BIRTHPLACE OF MOTHER (State or Country),

Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katerina Pospisil(Address) 2112 E Monument

15-

AUG 21 1915 W. W. Surclair
Filed 1915 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 21, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 2 1915, to Aug 21 1915, that I saw him alive on Aug 16 1915, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration)

2 yrs., 8 mos., 19 ds.

CONTRIBUTORY (Secondary)

(Duration)

2 yrs., 3 mos., 19 ds.

(Signed)

G. E. Pospisil M. D.Aug 21 1915 (Address) 2112 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs., 8 mos., 19 ds. In the State 2 yrs., 8 mos., 19 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Hill

DATE OF BURIAL,

Aug 24, 1915

20-UNDERTAKER,

Wm. X. Croach, Jr.

ADDRESS

1904 Chesapeake

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

808 N Chester

ST. 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

2-FULL NAME

Kate Heindold

(Residence in Baltimore: No.

808 N Chester

St. 6 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widowed

6-DATE OF BIRTH,

Sept 9, 1854
(Month) (Day) (Year)

7-AGE,

60 yrs. 11 mos. 10 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

Balto

10-NAME OF FATHER,

George Hebeleir

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Weinmiller

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

John A. Hebeleir

(Address).....

808 N Chester

15-

Filed:

191

Aug 21 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 15 1915, to Aug 19 1915,

that I saw him alive on Aug 19 1915,

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Chronic nephritis

(Signed)..... M. D.

Aug 19, 1915. (Address) 718 N Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Balto Cem

DATE OF BURIAL,

Aug 22, 1915.

20-UNDERTAKER

J. Herwig

ADDRESS

2008 E. E. Ave

C87645

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

117

C87645

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *4124* WARD)2-FULL NAME *Robert Lowe*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN aut No. 18.)

(Residence in Baltimore: No. *505 S Ellwood Ave* St. *4* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *White* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

January (Month) *10* (Day), *1911* (Year)

7-AGE

4 yrs. *8* mos. *10* ds. or *1* day, *hrs.* min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*none*9-BIRTHPLACE
(State or country)*Maryland*

10-NAME OF FATHER

*Thomas Lowe*11-BIRTHPLACE OF FATHER
(State or country)*md.*

12-MAIDEN NAME OF MOTHER

*Katherine Highsmith*13-BIRTHPLACE OF MOTHER
(State or country)*N.C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. J. Smith*(Address) *Johns Hopkins Hosp.*

15-

Filed

AUG 21 1915

191

Chas M. Muddair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

August (Month) *20* (Day), *1915* (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*August 19, 1915, to August 20, 1915,*that I saw him alive on *August 20, 1915,*and that death occurred, on the date stated above, at *9:30 P.M.*

The CAUSE OF DEATH* was as follows:

*General Peritonitis*Contributory
(SECONDARY)*Erysipela* (Duration) yrs. mos. *7* ds.(Signed) *Isador G. Zuck**August 21, 1915.* [Address] *Johns Hopkins Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. *1* ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *505 S Ellwood Ave*

19-PLACE OF BURIAL OR REMOVAL

Oak Lawn Cem

DATE OF BURIAL

Aug 25, 1915

20-UNDERTAKER

J. Herzig & Co

ADDRESS

1200 S. Blean

TION is very important. See instructions on back of certificate.

C87616

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87616

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

The Johns Hopkins Hosp.

ST.

WARD

2-FULL NAME

Frank B. Bass

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

3415 Myrtle Place

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

Jan. 1904
(Month) (Day) (Year)

7-AGE

11 yrs. mos. ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Chief

9-BIRTHPLACE
(State or country)

Maryland

10-NAME OF FATHER

John H. Bass

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Rosie Coulbrever

13-BIRTHPLACE OF MOTHER
(State or country)

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. Batten

(Address)

Johns Hopkins Hosp.

15-

Filed

191

Chas. M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 28, 1915, to Aug. 19, 1915, that I saw him alive on August 19, 1915, and that death occurred, on the date stated above, at 5:45 p.m. The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. 4 mos. ds.

Contributory (SECONDARY)

Acute Arteriosclerotic Rheumatism

(Duration) yrs. 2 mos. ds.

(Signed)

G. A. Batten

M. D.

Aug. 19, 1915. [Address] Johns Hopkins Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. 3 mos. 21 ds. In the State 11 yrs. mos. ds.

Where was disease contracted, if not at place of death? St. Helena Md.

Former or usual residence 3415 Myrtle Place

19-PLACE OF BURIAL OR REMOVAL

Benedict North Cem.

DATE OF BURIAL

Aug. 22, 1915

20-UNDERTAKER

Harry W. Ehlert

ADDRESS

1944 W. North Ave.

C87647

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87647

103

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1541 Carswell ST. 9 WARD)

2-FULL NAME

Hellen Blatchley(Residence in Baltimore: No. 1541 Carswell St. 9 yrs. 2 mos. 20 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

white5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Child

6-DATE OF BIRTH

June

(Month)

1, 1915

(Day) (Year)

7-AGE

2 yrs. 20 ds. or min.?If LESS than
1 day, hrs.,

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)None9-BIRTHPLACE
(State or country)1541 Carswell St
Baltimore Md

10-NAME OF FATHER

Walter Blatchley11-BIRTHPLACE OF FATHER
(State or country)Baltimore Md

12-MAIDEN NAME OF MOTHER

Catherine Kelly13-BIRTHPLACE OF MOTHER
(State or country)Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Catherine Blatchley

(Address)

1541 Carswell St

15-

AUG 21 1915

Charles M. Suckale

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August

(Month)

20, 1915

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

August 15, 1915, to, August 20, 1915,that I saw her alive on August 20, 1915,and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

GastritisContributory
(SECONDARY)

(Duration)

yrs.

mos. 10 ds.

(Signed)

Dr. J. J. Whitham

M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death

yrs.

mos.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Saint Marys CemeteryAug 22, 1915Henry Brock, Sr 1301 E. Eager

C87648

HEALTH DEPARTMENT—CITY OF BALTIMORE

87648

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 906 N Eden

ST. 100 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Annie T Barker

(Residence in Baltimore: No. 906 N Eden

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widows
6-DATE OF BIRTH, Oct 28, 1849
(Month) (Day) (Year)

7-AGE, 65 yrs. 9 mos. 2 ds.
If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE,
(State or Country),

Md

PARENTS.

10-NAME OF FATHER, Cornelius Caughton

11-BIRTHPLACE OF FATHER
(State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Johanna Shahan

13-BIRTHPLACE OF MOTHER
(State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Warrick

(Address) No 906 N Eden St.

15-

AUG 21 1915

191

Chas M Sinclair

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 20, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Cause

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Elyah L Russell M. D.
(Coroner.)

Aug 21, 1915 (Address) 423 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Cross Cemetery Aug 22 1915

20-UNDERTAKER

ADDRESS

Harry Hoecker Sr 1301 E Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No.

St.; yrs. mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, /

MARRIED

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant)

(Address)

15-

Filed

191

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87650

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2344 Wilkens Ave* ST.; *70* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *2344 Wilkens Ave* St.; *24* yrs., *5* mos. *17* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and full out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH.

Feb. 23, 1891
(Month) (Day) (Year)

7-AGE.

24 yrs., *5* mos., *27* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*
Housework

9-BIRTHPLACE, (State or Country).

Balta, Md.

10-NAME OF FATHER.

John Simon

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Matilda Simon
2344 Wilkens Ave
(Address)

15-

AUG 21 1915
Filed

191

Chas. M. Sullivan
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 20, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 4, 1915*, to *Aug 20, 1915*, that I saw her alive on *August 19, 1915*, and that death occurred, on the date stated above, at *10 a m.*

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis(Duration) *4* yrs., *16* mos., *16* ds.

CONTRIBUTORY (Secondary)

(Duration) *4* yrs., *16* mos., *16* ds.(Signed) *M. A. O'Neill* M. D.*Aug 21, 1915* (Address) *108 N. Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *24* yrs., *5* mos., *27* ds. In the State *24* yrs., *5* mos., *27* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

London Park

DATE OF BURIAL.

Aug 22 1915

20-UNDERTAKER

Geo. L. Schurab

ADDRESS

Bu. 2101 Fred Klue

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87651

C87651

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infirmary* ST.: *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs. *3* mos. *3* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) *Infant*

6-DATE OF BIRTH,

March 7, 1915
(Month) (Day) (Year)

7-AGE,

5 mos. 12 da.

IF LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE.

(State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1701 Division St.*

15-

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HEALTH DEPARTMENT—CITY OF BALTIMORE

C87652

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. ...)

2-FULL NAME

(Residence in Baltimore: No. ...)

Union Protestant Infirmary
Division ST.: ... WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: ... yrs. ... mos. 34 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, January 28, 1865
(Month) (Day) (Year)

7-AGE, 50 yrs. 7 mos. ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Mass.

10-NAME OF FATHER, George A. Curtis

11-BIRTHPLACE OF FATHER (State or Country), Mass.

12-MAIDEN NAME OF MOTHER, Mary Lewis

13-BIRTHPLACE OF MOTHER (State or Country), Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. E. Frank

(Address) 802 Madison Ave.

15- AUG 22 1915 191. C. E. Frank Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY. That I attended deceased from July 19 1915, to Aug 22 1915, that I saw him alive on Aug 22 1915, and that death occurred, on the date stated above, at 3:40 a.m.

The CAUSE OF DEATH* was as follows:

Trauma (kick of horse)
Rupture ureter, pure nephritic
Abscess, paralysis of bladder.
(Duration) ... yrs. ... mos. 42 ds.

CONTRIBUTORY ... Lobar pneumonia
(Secondary) (Duration) ... yrs. ... mos. 2 ds.

(Signed) ... M. D.

191... (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 34 ds. In the State ... yrs. ... mos. 34 ds.

Where was disease contracted, if not at place of death? Belair Md.

Former or usual residence Belair Md.

19-PLACE OF BURIAL OR REMOVAL, Fallston Md.

20-UNDERTAKER, Chas. E. Frank

DATE OF BURIAL, Aug 24, 1915.

ADDRESS, 802 Madison Ave.

C87653

HEALTH DEPARTMENT-CITY OF BALTIMORE

C87653

CERTIFICATE OF DEATH

PLACE OF DEATH

T. Ballman

REGISTERED NO. C

CITY OF BALTIMORE (No. 149-n High St

ST. 5

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Lewis

(Residence in Baltimore: No. 149-n High St

St. 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

W.

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

widowed

6-DATE OF BIRTH

Aug

(Month)

(Day)

1848

(Year)

7-AGE

72

yrs.

mos.

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

At Home

9-BIRTHPLACE

(State or country)

Russia

10-NAME OF FATHER

Samuel Kaplan

11-BIRTHPLACE OF FATHER

(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Ida Kalman

13-BIRTHPLACE OF MOTHER

(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ida Kaplan

(Address)

149-n High St.

15.

AUG 22 1915

C. H. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 21, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY. That I attended deceased from

July 17, 1915, to Aug 21, 1915,

that I saw him alive on Aug 21, 1915,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

Contributory (SECONDARY)

(Duration) yrs. mos. 21 ds

Pneumonia

(Signed)

Henry G. G. G. G. M. D.

Aug 21, 1915

(Address)

Henry G. G. G. G.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Burial

8/22, 1915

20-UNDERTAKER

ADDRESS

Jack Lewis

1479 E. Balto

is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

28 C87651

PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Frances Convent*)

REGISTERED NO. C

WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Ethel Williams*)St. *Car Forrest Chase* Str. *1* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6-DATE OF BIRTH *June 9, 1902*
(Month) (Day) (Year)

7-AGE *13* yrs. *2* mos. *12* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer) *Child*

9-BIRTHPLACE
(State or country)*New York State*

10-NAME OF FATHER

*Unknown*11-BIRTHPLACE OF FATHER
(State or country)*"*

12-MAIDEN NAME OF MOTHER

*"*13-BIRTHPLACE OF MOTHER
(State or country)*"*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mother Mary Frances
St. Frances Convent
(Address) *Car Chase St. & Forrest Pl.*

AUG 22 1915

191

Chas. M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 21, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1915 to *Aug 21, 1915*
that I saw her alive on *Aug 18, 1915*

and that death occurred, on the date stated above, at *1:30 pm*.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) yrs. *4* mos. ds.

Contributory
(SECONDARY)

(Signed) *Mary F. Beglein* M. D.
Aug 21, 1915 (Address) *1028 W. Beglein*

*State the DISEASE CAUSING DEATH, or, in deaths from violent causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. *6* mos. ds. In the yrs. *4* mos. ds.
Where was disease contracted, *none*
If not at place of death?
Former or usual residence *unknown*

19-PLACE OF BURIAL OR REMOVAL

Holy cross cemetery

DATE OF BURIAL

Aug 22, 1915

20-UNDERTAKER

Felix T. Pye

ADDRESS

1028 W. Beglein

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 W. Fayette ST.; 19 WARD)FULL NAME Margaret V. Criswell(Residence in Baltimore: No. 1529 W. Fayette St. St.; yrs. mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-STATUS, Widow
MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, Sept. 8, 1842
(Month) (Day) (Year)7-AGE, 72 yrs. 11 mos. 13 da. If LESS than 1 day, hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work, retired
(b) General nature of industry, business, or establishment in which employed (or employer), Housewife at Home9-BIRTHPLACE, (State or Country), W. Ia. =PARENTS.
10-NAME OF FATHER, Adam Small
11-BIRTHPLACE OF FATHER (State or Country), W. Ia. =
12-MAIDEN NAME OF MOTHER, Mary Meyers
13-BIRTHPLACE OF MOTHER (State or Country), W. Ia. =

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. J. Maister(Address) 2902 N. Calvert St.15-
AUG. 23, 1915 Chas. M. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 21, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 1st 1915, to Aug 21st 1915, that I saw her alive on August 21st 1915, and that death occurred, on the date stated above, at 6:45 P.M.The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage and debility from age..... (Duration) yrs. mos. da.
CONTRIBUTORY Arterio sclerosis
(Secondary)..... (Duration) 5 yrs. mos. da.
(Signed) Arthur Williams, M. D.
August 22nd 1915 (Address) Elk Ridge Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Falling Waters, Ia. = Aug. 23, 1915

20-UNDERTAKER, ADDRESS

E. M. Mitchell & Co. 1201 W. Fayette St.Beckley Co. -

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Canton Ave. ST.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Stefan Drawinski(Residence in Baltimore: No. 1609 Canton Ave. St.; 1 yrs., 7 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MarriedWidowedDivorced

(Write the word.)

6-DATE OF BIRTH

Dec 6, 1905
(Month) (Day) (Year)

7-AGE

1 yrs., 7 mos., 15 ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

NoneInfant

9-BIRTHPLACE

(State or Country),

Baltimore

10-NAME OF FATHER

John Drawinski

11-BIRTHPLACE OF FATHER

(State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Julia Marszalek

13-BIRTHPLACE OF MOTHER

(State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Drawinski
(Address) 1609 Canton Ave.

15-

AUG. 22, 1915 Chas. M. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 15, 1915, to Aug 22, 1915,that I saw him alive on Aug 22, 1915,and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed)

L. Martin M. D.Aug 22, 1915 (Address) 1609 Canton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

.....

.....

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary

DATE OF BURIAL

Aug 23, 1915

20-UNDERTAKER

William L. Palfour

ADDRESS

1618 Eastern Ave.

C87657 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.....

1-PLACE OF DEATH:

CITY OF BALTIMORE: (No. 1637 James St. 2)

2-FULL NAME Franciszek Kwarta

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1637 James St. 2)

St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

June 21, 1915
(Month) (Day) (Year)

7-AGE

2 yrs. 2 mos. ds. or min.?
If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)None
Infant9-BIRTHPLACE
(State or country)

Baltimore

PARENTS

10-NAME OF FATHER

Jendrzal Kwarta

11-BIRTHPLACE OF FATHER
(State or country)

Poland

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER
(State or country)

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jendrzal Kwarta

(Address)

1637 James St.

15-

AUG 22 1915
Filed..... 191

Chas. M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 16, 1915, to, Aug 21, 1915,

that I saw him alive on Aug 25, 1915,

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Gastric Intoxication

(Duration)..... yrs..... mos..... ds.

Contributory
(SECONDARY)

(Duration)..... yrs..... mos..... ds.

(Signed),

J. M. Minton

M. D.

Aug 21, 1915 [Address] 1637 James St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary

DATE OF BURIAL

Aug 22, 1915

20-UNDERTAKER

Jacob Gsalkowski

ADDRESS

428 S. Bond

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87658

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1128 E Lexington* ST. *5* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary Franklin*(Residence in Baltimore: No. *1128 E Lexington* St.; *31* yrs., *8* mos., *20* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Colored*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

November 30, 188*8*
(Month) (Day) (Year)

7-AGE.

31 yrs., *8* mos., *20* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Laundress*9-BIRTHPLACE.
(State or Country).*Baltimore Md*

10-NAME OF FATHER.

*James H Franklin*11-BIRTHPLACE OF FATHER
(State or Country).*Anne Arundel Co Md*

12-MAIDEN NAME OF MOTHER.

*Emma Bryan*13-BIRTHPLACE OF MOTHER
(State or Country).*Cambridge Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Emma Franklin

(Address)

1128 E Lexington St

15-

Filed Aug 22 1915

191

Chas. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 20, 191*5*
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *June 20* 191*5*, to *Aug 20* 191*5*, that I saw her alive on *August 20* 191*5*, and that death occurred, on the date stated above, at *10:30 P.M.*

The CAUSE OF DEATH* was as follows:

Tuberculosis(Duration) *1* yrs., *1* mos., *5* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs., *1* mos., *5* ds.(Signed) *M. D.**Aug 20*, 191*5*. (Address) *1364 N. Carey St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs., *1* mos., *5* ds. In the State *1* yrs., *1* mos., *5* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*1st Zion C**Aug 25*, 191*5*

20-UNDERTAKER

ADDRESS

Am J Jackson 1408 Mullikin St

C87659

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 C87659

PLACE OF DEATH

CITY OF BALTIMORE (No. *246 S. Bethel*)FULL NAME *Thomas J. Stanley*(Residence in Baltimore: No. *246 S. Bethel*)

REGISTERED NO. C

WARD) *3*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *50* yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

unknown, 1852
(Month) (Day) (Year)

7-AGE

63 yrs. — mos. — ds. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Laborer
Plasterer
& Brick Layer*

9-BIRTHPLACE

(State or country)

Maryland

10-NAME OF FATHER

William Stanley

PARENTS

11-BIRTHPLACE OF FATHER

(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER

(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maiah Griffin

(Address)

246 S. Bethel

15-

AUG 22 1915

Chas M. Snelan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 17, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from

*July 6 - 1915 to Aug 18 - 1915*that I saw him alive on *Aug 19 - 1915*and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Contributory (SECONDARY)

Diarrhoea
(Duration) yrs. 1 mos. 13 ds.

(Signed)

M. D. Harris
(Duration) yrs. 8 mos. 8 ds.*Aug 20 - 1915*(Address) *1716 S. Patton St*

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Long Green Cemetery**Aug 23, 1915*

20-UNDERTAKER

ADDRESS

Theodore White 1702 Soaght

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2631 Francis ST. 13 WARD)2-FULL NAME Myrtle N. Emnis(Residence in Baltimore: No. 2631 Francis

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 6 yrs., 10 mos. 19 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

10th 2, 1908
(Month) (Day) (Year)

7-AGE,

6 yrs., 10 mos., 19 da.If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Chlor
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),Balto City

10-NAME OF FATHER,

Wilmer Emnis11-BIRTHPLACE OF FATHER
(State or Country),Ind

12-MAIDEN NAME OF MOTHER

Ethel M Foxwell13-BIRTHPLACE OF MOTHER
(State or Country),Mayland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilmer Emnis(Address) 2631 Francis

15-

AUG 22 1915

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 21, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 6 1915, to Aug 21 1915,that I saw h. alive on Aug 21 1915,and that death occurred, on the date stated above, at 1130 m.

The CAUSE OF DEATH* was as follows:

(Duration).....yrs.....mos.....da.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....da.

(Signed) J. J. McLaughlin M. D.Aug 21, 1915 (Address) 1303 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn Cem

DATE OF BURIAL,

Aug 22, 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 542 Oxford ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bettie Wilkinson(Residence in Baltimore: No. 542 Oxford St.; 47 yrs., 1 mos., 1 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female4-COLOR OR RACE, colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widow
(Write the word.)6-DATE OF BIRTH, Feb 17, 1915

(Month)

(Day)

(Year)

7-AGE, 66 yrs., 1 mos., 1 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Laundress

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.10-NAME OF FATHER, Alex. Spiller11-BIRTHPLACE OF FATHER (State or Country), Va.12-MAIDEN NAME OF MOTHER, Hallie Smith13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Priscilla P. Fitzhugh(Address) 542 Oxford Street

15-

AUG 22 1915

191

Chas. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 19, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from Feb 17, 1915, to Aug 19, 1915,that I saw her alive on Aug 18, 1915,and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum
(Mucocystic carcinoma)(Duration)..... yrs. 6 mos. 1 ds.CONTRIBUTORY (Secondary) General Exhaustion(Duration)..... yrs. 30 mos. 30 ds.(Signed) Mrs. H. ThompsonAug 19, 1915 (Address) 1019 N. Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel CemeteryDATE OF BURIAL, Aug 22, 191520-UNDERTAKER, George H. HollandADDRESS Robert St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 N. Hollington ST.; 6 WARD)2-FULL NAME Laura B. Smith(Residence in Baltimore: No. 211 N. Hollington St.; 38 yrs., 1 mos. 20 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

July 1, 1877

7-AGE,

38 yrs., 1 mos., 20 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work,.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Housework
at home

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

AUG 22 1915

191

Ellis Blair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 21, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1915, Aug 31, 1915that I saw her alive on August 21, 1915and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....

(Duration)..... yrs..... mos..... ds.

(Signed) Edward J. Corcoran M. D.

....., 1915. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

St. CarmelAug 24 1915

20-UNDERTAKER

Philip HenryADDRESS 2016Oleons

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *St Joseph Hospital*)

ST. *2*

WARD

2-FULL NAME *Howard F Ward*

(Residence in Baltimore: No. *1812* *Truagh*)

REGISTERED No. C. *186*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.) *5*

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*

4-COLOR OR RACE, *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)

6-DATE OF BIRTH, *May 6, 1890*

(Month)

(Day)

(Year)

7-AGE, *25* yrs. *3* mos. *4* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Carpenter*
(b) General nature of industry, business, or establishment in which employed (or employer), *General*

9-BIRTHPLACE, (State or Country), *md*

10-NAME OF FATHER, *Wm H Ward*

11-BIRTHPLACE OF FATHER, (State or Country), *md*

12-MAIDEN NAME OF MOTHER, *Louise Barringer*

13-BIRTHPLACE OF MOTHER, (State or Country), *md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alfred Ward*

(Address) *2106 Westwood Ave*

15-

Filed *AUG 22 1915*, 191

Chas F Sudair
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 20, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*, and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull (Accident) due to blow on head by a piece of timber at Miller's Fertilizer works foot of Clinton St.

CONTRIBUTORY (Secondary)

(Signed) *Elijah S. Russell*

(Coroner.)

Aug 21, 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death...yrs...mos. *2* ds. In the *25* *3* *4* yrs. mos. ds.

Where was disease contracted, if not at place of death? *Miller's Fertilizing Works foot of Clinton St.*
Former or usual residence *1812 Truagh St.*

19-PLACE OF BURIAL OR REMOVAL, *Mt Olivet Cemetery*

DATE OF BURIAL, *Aug 23 1915*

20-UNDERTAKER, *F. A. Krause*

ADDRESS, *703 Hanover*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 N. Mount ST.; 15 WARD)

REGISTERED NO. C

FULL NAME Margie Abrams.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1605 N. Mount St.; — yrs., — mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)6-DATE OF BIRTH. July 20th, 1915
(Month) (Day) (Year)7-AGE, — yrs., — mos., 30 ds. It LESS than 1 day, — hrs. or — min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Not any
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country), Baltimore10-NAME OF FATHER, Jos. F. Abrams11-BIRTHPLACE OF FATHER (State or Country), Calvert Co. Md.12-MAIDEN NAME OF MOTHER Elizabeth Rice13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Abrams(Address) 1605 N. Mount St.15- Aug 22 1915 191. Chas. W. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 20th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from August 15 1915, to August 19th 1915, that I saw her alive on August 19th 1915, and that death occurred, on the date stated above, at 7 1/2 m.

The CAUSE OF DEATH* was as follows:

Acute Inanition(Duration) — yrs., — mos., 5 ds.CONTRIBUTORY. Inability to assimilate
(Secondary)(Duration) — yrs., — mos., 20 ds.(Signed) William J. Sullivan M. D.820, 1915. (Address) 1701 N. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Mt Zion DATE OF BURIAL, Aug 22, 1915.20-UNDERTAKER James H. Dennis ADDRESS 1303 Resister

C87666

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87666

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 N. Mount

ST.: 15 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1916 Broun

St.: 8 yrs., 2 mos., 1 ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH,

June 20, 1896
(Month) (Day) (Year)

7-AGE,

8

yrs. 2 mos. 1 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

School Girl

9-BIRTHPLACE, (State or Country).

Maryland

10-NAME OF FATHER,

Amos Porter Johnson

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Leala Young

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Filed 3-3-1915

191

Chas M. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 21, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug. 16th 1915, to Aug. 21st 1915, that I saw her alive on Aug. 21st 1915, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Coronary Spinal Meningitis

(Duration) ... yrs. ... mos. 16 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. 5 ds.

(Signed) M. W. Shook M. D.

Aug. 21, 1915. (Address) 806 Preston Ave.
Gen. Pract. Res. Phys. Hahnemann Univ. Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 6 ds. In the 8 yrs. 2 mos. 1 ds. State

Where was disease contracted, if not at place of death?

At home

Former or usual residence

1471 Myrtle Ave

19-PLACE OF BURIAL OR REMOVAL

Baltimore City Cemetery

DATE OF BURIAL,

Aug. 22, 1915

20-UNDERTAKER

James H. Dennis

ADDRESS

1303 Preston Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *42 & N. Collington Ave* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *42 & N. Collington Ave* St.; *14* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

*Sept**12**1892*

(Month)

(Day)

(Year)

7-AGE,

22 yrs. *11* mos. *8* ds.

If LESS than 1 day.

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Telegraph

(b) General nature of industry, business, or establishment in which employed (or employer).

B & O R R

9-BIRTHPLACE,

(State or Country).

Hullersville Md

10-NAME OF FATHER,

James F. Brown

11-BIRTHPLACE OF FATHER

(State or Country).

Md

12-MAIDEN NAME OF MOTHER

Mary L. Pabel

13-BIRTHPLACE OF MOTHER

(State or Country).

Bath Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary L. Brown

(Address)

42 & N. Collington Ave

15-

Filed

AUG 22 1915

191

Chas. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*August**20**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 26 191*4*, to *Aug 20* 191*5*.that I saw him alive on *Aug 20* 191*5*,and that death occurred, on the date stated above, at *6 A* m.

The CAUSE OF DEATH* was as follows:

*Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent**Intermittent Intermittent*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87668

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 407 W. Kenwood Ave WARD) REGISTERED No. C 79
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)
2-FULL NAME George T. Eoker
(Residence in Baltimore: No. 407 W. Kenwood Ave 20 yrs. 7 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widower
(Write the word.)
6-DATE OF BIRTH, Jan 29, 1843
(Month) (Day) (Year)
7-AGE, 72 yrs. 7 mos. 22 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Builder
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Carroll Co. Md.

PARENTS.
10-NAME OF FATHER, John Eoker
11-BIRTHPLACE OF FATHER (State or Country), Penna.
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary S. Payne
(Address) 407 W. Kenwood Ave

15-
Filed AUG 28 1915 Chas. M. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug 20, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 6, 1915, to Aug 20, 1915, that I saw h. unalive on Aug 20, 1915, and that death occurred, on the date stated above, at 7:15 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema
Cardiac Stimulation
.....
..... (Duration).....yrs.....mos.....ds.
CONTRIBUTORY.....
(Secondary).....
..... (Duration).....yrs.....mos.....ds.
(Signed) R. Kelly.....M. D.
....., 191... (Address) Linwood & Garrison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs. 6 mos. 22 ds. In the State MD.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn DATE OF BURIAL, Aug 23, 1915.

20-UNDERTAKER Lilly & Zeiler ADDRESS 403 R. W. H.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87671

CERTIFICATE OF DEATH

PLACE OF DEATH

Albert Beltjeski

REGISTERED NO. C

CITY OF BALTIMORE (No.

502 J. Ann

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Albert Beltjeski

(Residence in Baltimore: No.

502 J. Ann

Str. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

6-DATE OF BIRTH *August 17, 1915*
(Month) (Day) (Year)

7-AGE *5* yrs. *5* mos. *5* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION *None*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Baltimore Md*

10 NAME OF FATHER *Marion Beltjeski*

11 BIRTHPLACE OF FATHER (State or country) *Poland Russia*

12 MAIDEN NAME OF MOTHER *Katharine*

13 BIRTHPLACE OF MOTHER (State or country) *Germany Poland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Katharine Beltjeski*

(Address) *502 J. Ann St.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *August 22, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *August 17, 1915* to *August 22, 1915* that I saw him alive on *August 21, 1915* and that death occurred, on the date stated above, at *9 A* in. The CAUSE OF DEATH* was as follows:

Branch Pneumonia & Asthma

Contributory (SECONDARY)

(Duration) yrs. mos. *5* ds.

(Signed) *Henry A. Rutledge* M. D. *8/22, 1915* (Address) *106 Jackson St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Stanislaus

DATE OF BURIAL

Aug 23, 1915

20-UNDERTAKER

M. F. Sadowski

ADDRESS

705 J. Ann St.

15 AUG 23 1915

ROBERT KRAUTER

Mutual Permit Clerk

Filed

Hoch

REGISTRAR

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. 1 d.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH,

Aug

21

1915

(Month)

(Day)

(Year)

7-AGE,

0 yrs. 0 mos. 1 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Napoleon Laniewski

11-BIRTHPLACE OF FATHER

(State or Country),

Russia Poland.

12-MAIDEN NAME OF MOTHER

Takla Marshal.

13-BIRTHPLACE OF MOTHER

(State or Country),

Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Napoleon Laniewski

(Address) 2515 Fair Ave

15-

AUG 23 1915

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August

(Month)

22, 1915

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from August 21 1915, to August 22 1915, that I saw him alive on August 22 1915, and that death occurred, on the date stated above, at 9 P. m. The CAUSE OF DEATH* was as follows:

General debility

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Laniewski M. D.

August 22 1915 (Address) 2515 Fair Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

Aug. 23, 1915

20-UNDERTAKER

M. J. Sadowski

ADDRESS

705 S. Ann St

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8)

3510 Benson Street

ST.

WARD)

2-FULL NAME

Rachel M. Wilson

(Residence in Baltimore: No. 3510 Benson Street

St.; 80 yrs. mos. ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

widowed

6-DATE OF BIRTH

March

6

1

835

(Month)

(Day)

(Year)

7-AGE

80

yrs.

5

mos.

15

ds.

or

min.?

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Housewife

9-BIRTHPLACE

(State or country)

Maryland

PARENTS

10-NAME OF FATHER

Greenfield Penn

11-BIRTHPLACE OF FATHER

(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Merrick

13-BIRTHPLACE OF MOTHER

(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Mr. James Wilson

(Informant)

Mt. Washington Hts.

(Address)

15-

AUG 23 1915

ROBERT . KRAUTER

Filed

191

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 21 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 17, 1915, to, Aug 21, 1915,

that I saw her alive on Aug 21, 1915,

and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Fracture of Hip & re -
Sitting (Shock)
Accidental fall down stepsContributory
(SECONDARY)

Shock

(Duration)

yrs.

mos.

ds.

(Signed),

Aug 21, 1915 [Address] M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place

yrs.

mos.

In the

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Marys cemetery

DATE OF BURIAL

Mon. Aug. 23, 1915

20-UNDERTAKER

A.S. Marshall

ADDRESS

3539 Falls Road

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *718 N Gay*)

2-FULL NAME *Andrew J. Armstrong*

(Residence in Baltimore: No. *718 N Gay*)

St.: *10* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *60* yrs., *60* mos. *60* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, *Widower*
MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *Unknown*, *1*
(Month) (Day) (Year)

7-AGE, *78* yrs., *60* mos., *60* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Mill Hand*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *md*

10-NAME OF FATHER, *James Armstrong*
11-BIRTHPLACE OF FATHER (State or Country), *Ireland*
12-MAIDEN NAME OF MOTHER, *Isabelle Buchanan*
13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Armstrong*
(Address) *718 N. Gay St.*

15-AUG 23 1915

ROBERT K. RAUTER,

MUNICIPAL PERMIT CLERK, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 22*, *1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*
(Inquest, au-

Inquest and that said deceased came to *the* death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Heart Disease
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Elyah J. Russell*, M. D.
(Coroner.)

Aug 23, 1915 (Address) *424 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Balto Cem* DATE OF BURIAL, *Aug 25*, 1915

20-UNDERTAKER, *Albert E. Fuller* ADDRESS, *2211 B'dway*

C87675

HEALTH DEPARTMENT—CITY OF BALTIMORE

81 C87675

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital

ST. WARD)

2-FULL NAME

William E. Watkins

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

(Residence in Baltimore: No.

1615 Orleans St

St.; 35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

May

(Month)

4

(Day)

1880

(Year)

7-AGE

35

yrs.

mos.

ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

Laborer

9-BIRTHPLACE
(State or country)

Md

10-NAME OF
FATHER

Wm. Watkins

PARENTS

11-BIRTHPLACE
OF FATHER
(State or country)

Md.

12-MAIDEN NAME
OF MOTHER

Alberta Tubman

13-BIRTHPLACE
OF MOTHER
(State or country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Smith

(Address)

Johns Hopkins Hosp.

15-

AUG 23 1915

ROBERT . KRAUTER,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August

(Month)

20

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1, 1915, to August 20, 1915,

that I saw him alive on August 20, 1915,

and that death occurred, on the date stated above, at 10:71 p.m.

The CAUSE OF DEATH* was as follows:

Rupture of Aneurysm of aorta.

(Duration)

yrs

mos.

ds.

Contributory
(SECONDARY)Aneurysm of aorta (degenerative)
patent

(Duration)

yrs

mos.

ds.

(Signed)

Stanhope Beane Jones M. D.

August 21, 1915

[Address]

Johns Hopkins Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place
of death

yrs

mos

ds.

In the

State

yrs

mos

ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

1615 Orleans St

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laural Cemetery Aug 23, 1915

20-UNDERTAKER

ADDRESS

Robert A. Elliott 506 Rodgers Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11. 7. Mount ST. 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Gundle(Residence in Baltimore: No. 11. 7. Mount St.; yrs. life mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married6-DATE OF BIRTH July 21, 1837

(Month)

(Day)

(Year)

7-AGE 78 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Balto md10-NAME OF FATHER, Jacob Nils11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E. Rose(Address) 11. 7. Mount St

AUG 23 1915

ROBERT . KRAUTER,
Burial Permit Clerk

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 21, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1 1915, to Aug. 19 1915,that I saw h 4 alive on Aug. 19 1915,
and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Heart Failure
(Duration)..... yrs. mos. ds.CONTRIBUTORY (Secondary) Coronary(Signed) R. E. Krauter M. D.
Aug 23, 1915 (Address) 1405 E. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto cemeteryDATE OF BURIAL, Aug 23, 191520-UNDERTAKER John E. KrauterADDRESS 14424 Bway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No.

St.; 0 yrs., 0 mos., 7 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, OR DIVORCED

(Write the word.)

6-DATE OF BIRTH,

7-AGE,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

AUG 23 1915

ROBERT J. KRAUTER,

Municipal Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) P. S. Rush M. D.

8-21, 1915 (Address) University / Kay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

COLLEGE OF P. & S.

AUG 23 1915

20-UNDERTAKER

ADDRESS

Commissioner Health.

FOR ANATOMICAL PURPOSES.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *124* WARD) *145*

2-FULL NAME *Pattie Gunn*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *536 Robert St* St. *unknown* yrs. *unknown* mos. *unknown* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.,

ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

August 20, 191*5*, to, *August 22*, 191*5*,

that I saw her alive on *August 22*, 191*5*, and that death occurred, on the date stated above, at *3:20* a.m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

Contributory (SECONDARY)

(Signed)

August 22, 191*5*

[Address]

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. *2* mos. *2* ds. In the State, yrs. *✓* mos. *✓* ds. *✓*

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Scapier H. C.

Aug 23, 191*5*

20-UNDERTAKER

ADDRESS

John A. Bishop

1107

15-

AUG 23 1915

ROBERT . KRAUTER,

MARIAL Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-AUG 23 1915

Filed..... 191

ROBERT KRAUTER,

Chief Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, autopsy or inquiry.)

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Laparotomy (Septicemia) caused by accidentally stopping in front of a moving locomotive.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Moses M. Savage, M. D.

(Coroner.)

(Address) 1714 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos. 2 ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

at Bay View Junction

Former or usual residence.. 1137 S. Clinton

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Sacred Heart Cemetery

Aug 24, 1915

20-UNDERTAKER

Zinkler + Zinkler

ADDRESS

1739 E. Eager St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 E. Monument ST.; 10 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1420 E. Monument St.; 15 yrs., mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Col.5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH,

Aug. 25, 1864?
(Month) (Day) (Year)

7-AGE,

50 yrs. 11 mos. 26 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Koss(Address) 1420 E. Monument St.

15-AUG 23 1915 ROBERT KRAUTER,

Filed..... 191. BUREAU. FARMER. OLIVER.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 5, 1915, to Aug. 22, 1915,
that I saw her alive on Aug. 21, 1915,
and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Bronchiectasis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) J. B. Robinson M. D.Aug. 22, 1915 (Address) 611 N. Calver St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Taylor Island Md Aug. 24, 1915.

20-UNDERTAKER

ADDRESS

R. C. Cross 1405 Meade St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87682

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

1727 Carlyle Place

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1727 Carlyle Place

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Sarah Mather Carroll

(Residence in Baltimore: No.

1727 Carlyle Place

St.; 40 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Caucasian

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

May

19

1869

(Month)

(Day)

(Year)

7-AGE,

46

yrs., mos., da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

At Home.

9-BIRTHPLACE,

(State or Country),

Md

10-NAME OF FATHER,

Hubanett Mather

11-BIRTHPLACE OF FATHER

(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Harriet Jones

13-BIRTHPLACE OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James S. Carroll

(Address)

1727 Carlyle Place

15-

ROBERT KRAUTER

Filed

AUG 23 1915

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August

22

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

21 Aug

1915

to 22 Aug

1915

that I saw her alive on 21 Aug 1915

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 8 mos. da.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. da.

(Signed) M. C. Sandrock M. D.

Aug. 23, 1915 (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Maggie Adams Co

DATE OF BURIAL,

Aug. 24, 1915

20-UNDERTAKER

ADDRESS

R. E. Gross 1405 McElarry St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
 CITY OF BALTIMORE (No. *Mary Hospital*) ST. *23* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 FULL NAME *Buster Tucker*
 (Residence in Baltimore: No. *901 S. Sharp St.* St.: yrs. *life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Child*
 6-DATE OF BIRTH, *March 26, 1912* (Month) (Day) (Year)
 7-AGE, *3* yrs. *1* mos. *16* ds. If LESS than 1 day, ... hrs. or ... min.
 8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Child* (b) General nature of industry, business, or establishment in which employed (or employer).
 9-BIRTHPLACE, (State or Country), *City*
 10-NAME OF FATHER, *George Tucker*
 11-BIRTHPLACE OF FATHER (State or Country), *Va*
 12-MAIDEN NAME OF MOTHER *Phillis Venia*
 13-BIRTHPLACE OF MOTHER (State or Country), *Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George Tucker*
 (Address) *901 S. Sharp St.*

15-

AUG. 23, 1915 *Chas M. Sinclair*
 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 21, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, Autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, Autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Accident. Fell off porch.
3rd story back porch.

(Duration) yrs. mos. ds.
 CONTRIBUTORY *Fracture skull* (Secondary)

(Signed) *Thos. H. Chambers* M. D. (Coroner.)
August 23, 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the *3* yrs. *1* mos. *16* ds.

Where was disease contracted, if not at place of death?.....

901 S. Sharp St.
 Former or usual residence *901 S. Sharp St.*

19-PLACE OF BURIAL OR REMOVAL, *Mt Auburn* DATE OF BURIAL, *Aug. 23, 1915*

20-UNDERTAKER *L. L. Brown & Son* ADDRESS *108 N. Howard*

C87684

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Archie Clark*(Residence in Baltimore: No. *125 St. Montgomery* St.; *life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE. *Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)6-DATE OF BIRTH. *Unknown* 1

(Month)

(Day)

(Year)

7-AGE. *1/2?*

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Labort*
(b) General nature of industry, business, or establishment in which employed (or employer). *Day*9-BIRTHPLACE, (State or Country), *MD.*10-NAME OF FATHER. *Not Known*11-BIRTHPLACE OF FATHER (State or Country). *Not Known*12-MAIDEN NAME OF MOTHER. *Not Known*13-BIRTHPLACE OF MOTHER (State or Country). *Not Known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). *Asa M. Morcott*(Address). *Calvert St.*

15-

Filed *AUG 23 1915**Chas M. Sinclair*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 23, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 14* 1915, to *Aug 23* 1915, that I saw him alive on *Aug 23* 1915, and that death occurred, on the date stated above, at *10:09* m.

The CAUSE OF DEATH* was as follows:

Epilepsy(Duration) *10 min.*

yrs.

mos.

ds.

CONTRIBUTORY (Secondary) *Exhaustion following convulsions*(Duration) *7*

yrs.

mos.

ds.

(Signed) *Edward M. Smith*

M. D.

Aug 23 1915(Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

125 St. Montgomery

Former or usual residence

*125 St. Montgomery*19-PLACE OF BURIAL OR REMOVAL, *Mt. Auburn*DATE OF BURIAL, *Aug 25, 1915*20-UNDERTAKER *S. L. Brown & Son*ADDRESS *10 St. Montgo*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1133 Hanover*

2-FULL NAME

Edward A. Frank(Residence in Baltimore: No. *1133 Hanover*

REGISTERED No. C

ST.: *23* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *26* yrs., *7* mos., *26* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

*Dec.**27**1888*

(Month)

(Day)

(Year)

7-AGE,

*26**7**26*

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Clerk

9-BIRTHPLACE,

(State or Country),

Balto., Md.

10-NAME OF FATHER,

Harry G. Frank

11-BIRTHPLACE OF FATHER

(State or Country),

Balto., Md.

12-MAIDEN NAME OF MOTHER

Annie Bailey

13-BIRTHPLACE OF MOTHER

(State or Country),

Balto., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Harry G. Frank

(Address)...

1133 Hanover St.

15-

AUG 23 1915

Filed.....

191

Chas. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Aug.**23**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 191*3*, to *Aug* *23* 191*5*,that I saw him alive on *Aug* *22* 191*5*,and that death occurred, on the date stated above, at *1 a* m.

The CAUSE OF DEATH* was as follows:

*Pulmonary**tuberculosis**(Duration) 1 yrs. 11 mos. 26 ds.*CONTRIBUTORY.....
(Secondary)*(Duration) 1 yrs. 11 mos. 26 ds.*(Signed) *Charles O. Brown* M. D.*Aug 23* 191*5* (Address) *5 E. Red St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral Cemetery**Aug 24, 1915*

20-UNDERTAKER

ADDRESS

*H. & M. S. Flynn**1422 Light St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; ... WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country),10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Filed

AUG. 23, 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
July 14 1915, to Aug. 21 1915,
that I saw her alive on Aug. 21 1915,
and that death occurred, on the date stated above, at 2:58 P. m.

The CAUSE OF DEATH* was as follows:

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

Aug. 22, 1915 (Address) 1279 Melrose St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran-
sients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cemetery Aug. 24, 1915

20-UNDERTAKER

ADDRESS

H. M. E. Flynn 1922 Light St.

C87687

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87687

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1104 Peach ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. McCarly(Residence in Baltimore: No. 1104 Peach St. yrs. 10 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

IF LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)9-BIRTHPLACE
(State or country)10-NAME OF
FATHER11-BIRTHPLACE
OF FATHER
(State or country)12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY. That I attended deceased from

that I saw him alive on
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:Contributory
(SECONDARY)

(Signed),

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

is very important. See instructions on back of certificate.

AUG 23 1915

Filed

1915

Chas M. Sueda

REGISTRAR

St. Patrick's Cemetery
H. M. J. FlynnAug 24 1915
1425 E. 1st St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Sts.* *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Ida Norberg*(Residence in Baltimore: No. *1405' Dungan alley* *Duker* St.; *life time* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH

Not Known 1 (Month) (Day) (Year)

7-AGE

45 yrs. mos. da.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *House Wife*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Baltimore

10-NAME OF FATHER

John Cole

11-BIRTHPLACE OF FATHER (State or Country).

Baltimore

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER (State or Country).

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ida Norberg*(Address) *1405' Dungan alley*

15-

Filed

AUG 23 1915

191

Chas M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

August *23*, 191*5* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *aug 19* 191*5*, to *aug 23* 191*5*; that I saw her alive on *aug 23* 191*5*; and that death occurred, on the date stated above, at *11 a.m.*

The CAUSE OF DEATH* was as follows:

apoplexy(Duration) ... yrs. ... mos. ... da. *12*

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... da.

(Signed) *Geo. H. Buarr* M. D.*aug 23*, 191*5* (Address) *Franklin Sq. Sts.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *5* da. In the State *life time* mos. ds.Where was disease contracted, if not at place of death? *at home*Former or usual residence *1405' Dungan alley*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*Mt. Carmel**Aug. 25*, 191*5*

20-UNDERTAKER

ADDRESS

Wendell Lippel & Son *303 S. Bond*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 N. Calver St. 71

ST. WARD)

2-FULL NAME

Geo. Cassine

(If death occurred in a hospital or institution, give its NAME instead of street and number and R.N. No. 18.)

(Residence in Baltimore: No. 821 N. Calver St.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widower

6-DATE OF BIRTH

Jan

7-1873
(Month) (Day) (Year)

7-AGE

42 yrs. 7 mos. 15 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Helper
DeWagne

9-BIRTHPLACE
(State or country)

Baltimore City

PARENTS

10-NAME OF FATHER

Dominic Cassine

11-BIRTHPLACE OF FATHER
(State or country)

Balto., Md.

12-MAIDEN NAME OF MOTHER

Annie Holley

13-BIRTHPLACE OF MOTHER
(State or country)

St. Mary's Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jennie Barrell

(Address)

809 N. Calver St.

15-

Filed

AUG 23 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15, 1915, to, 22nd 1915, that I saw him alive on Aug 20th 1915, and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Typhlo Pneumonia
(Duration) about 15 ds.

Contributory
(SECONDARY)

(Signed) R. F. Mackay
Aug 23, 1915 [Address] 833 S. Calver St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. James

Aug 25, 1915

UNDERTAKER

ADDRESS

John J. Cowan 901 Hollins

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Eastern Ave ST.; V WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1809 Eastern Ave St.; 2 yrs., 2 mos., 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word.)6-DATE OF BIRTH, May 31, 1915
(Month) (Day) (Year)7-AGE, 2 yrs., 22 mos., 22 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

None
Infant.9-BIRTHPLACE,
(State or Country),Baltimore.10-NAME OF FATHER, W. Belkine11-BIRTHPLACE OF FATHER (State or Country), Russian Poland12-MAIDEN NAME OF MOTHER, Katherine Weyasz13-BIRTHPLACE OF MOTHER (State or Country), Baltimore.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Belkine(Address) 1809 Eastern

15-AUG 23 1915

Filed..... 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 23, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1915, to Aug 23 1915, that I saw h. alive on Aug 20 1915, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

East Stents

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

Aug 20, 1915. (Address) 16 S. Sandy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rovers Aug 24, 1915.

20-UNDERTAKER

ADDRESS

William Fialkowski 1618 Eastern

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87691

CERTIFICATE OF DEATH.

63 C87691

PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 N. Spring ST.; 3 WARD)FULL NAME Hellie B. Carter(Residence in Baltimore: No. 804 N. Spring St. St.; 3 yrs., — mos., — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Black5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Single

6-DATE OF BIRTH,

Feb 12, 1900
(Month) (Day) (Year)

7-AGE,

15 yrs., 5 mos., 10 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework
General

9-BIRTHPLACE,

(State or Country).

Tennessee

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Curtis(Address) 720 N. Caroline St.

15-

AUG 23 1915

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Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 12, 1915 to Aug 22, 1915that I saw her alive on Aug 22, 1915and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Transverse MyelitisDuration not known
(Duration) (Day) (Month) (Year)

CONTRIBUTORY (Secondary)

Intestinal Toxemia
(Duration) about 10 mos. 10 ds.(Signed) Edward P. Smith M. D.
Aug 22, 1915 (Address) Marcy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 3 yrs., — mos., — ds. In the 9 yrs., — mos., — ds. State — yrs., — mos., — ds.Where was disease contracted, if not at place of death? 804 N. Spring St.Former or usual residence 804 N. Spring St.

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

August 26, 1915

20-UNDERTAKER

Felix B. Pye

ADDRESS

1026 Mulberry St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1519 North Caroline St. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Carroll Sheehan

(Residence in Baltimore: No. 1519 North Caroline Street, St.; 12 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, May 14, 1903, 1 (Month) (Day) (Year)

7-AGE, 12 yrs., 3 mos., 7 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Timothy V. Sheehan

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Elizabeth G. Fitzpatrick

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth Sheehan

(Address) 1519 N. Caroline St.

15-

Filed 1915 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 21, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 21, 1915, to Aug 21, 1915, that I saw him alive on Aug 20, 1915, and that death occurred, on the date stated above, at 10³⁰ Am.

The CAUSE OF DEATH* was as follows:

Acute endo and myo-carditis following acute rheumatic fever (Duration) 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of heart (Duration) 12 hrs. ds.

(Signed) E. H. Haymond M. D.

S. 28, 1915. (Address) P. O. Box 728, Pres. Co.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Aug 24, 1915

20-UNDERTAKER, Henry W. Means & Son 805 N. Calver St.

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 Linden Ave ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1225 Linden AveSt.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

....., 1
(Month) (Day) (Year)

7-AGE,

56 yrs. mos. ds.If LESS than 1 day.
..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Commission
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant9-BIRTHPLACE,
(State or Country),Rochester N. Y.

10-NAME OF FATHER,

Do not know11-BIRTHPLACE OF FATHER
(State or Country),do do

12-MAIDEN NAME OF MOTHER

do do13-BIRTHPLACE OF MOTHER
(State or Country),do do

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary W. Bentley(Address) 1225 Linden Ave

15-

Filed.....

1915Chas. A. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 22, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from August 20 1915, to August 22 1915, that I saw him alive on August 22 1915, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis with Mitral Regurgitation
with Acute Dilatation of Heart
Myocarditis about 4 1/2 yrs.
Dilatation of Heart (Duration) yrs. mos. ds. 6 M.CONTRIBUTORY
(Secondary)Arteriosclerosis
(Duration) 4 yrs. mos. ds.
(Signed) L. W. Bentley M. D.
August 22 1915. (Address) 2224 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL,

Aug. 24, 1915

20-UNDERTAKER

Harry W. Marshall

ADDRESS

805 N. Calvert St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87694

CERTIFICATE OF DEATH.

104 C87694
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1841 C. Lombard St.; 2 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1810 C. Pratt

St.; yrs., 7 mos. 17 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH,

Jan 6, 1915 (Month) (Day) (Year)

7-AGE,

7 yrs., 17 mos., 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, as home (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Md. Balto.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

AUG 24 1915

ROBERT J. KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 23, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 19, 1915, to Aug 23, 1915,

that I saw him alive on Aug 22, 1915,

and that death occurred, on the date stated above, at 2-a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) A. C. Gumbleson M. D.

Aug 23, 1915 (Address) 2013 3rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn Cem.

DATE OF BURIAL,

Aug 24, 1915

20-UNDERTAKER

J. J. Kerr 1914 E. Fayette

ADDRESS

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 869 Watts ST. 13 WARD)

2-FULL NAME Mary V. Brown

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 869 Watts St. St.; 4 yrs. 4 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE Col 5-SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH April 1 1915
(Month) (Day) (Year)

7-AGE 4 yrs. 4 mos. 21 ds. or 1 day, 4 hrs. 21 min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balta, Md.

PARENTS:
10-NAME OF FATHER Lee Miles
11-BIRTHPLACE OF FATHER (State or country) Maryland
12-MAIDEN NAME OF MOTHER Mary Brown
13-BIRTHPLACE OF MOTHER (State or country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martha Brown
(Address) 869 Watts St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug 22 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 18, 1915, to, Aug 22, 1915, that I saw her alive on Aug 22, 1915, and that death occurred, on the date stated above, at 8 o'clock p.m.

The CAUSE OF DEATH* was as follows:

Dysentery
(Gastro-Intestinal)
(Duration) 7 yrs. 7 mos. 7 ds.

Contributory (SECONDARY) Exhaustion
(Duration) 1 yrs. 1 mos. 1 ds.
(Signed), H. L. Pelletier M. D.
Aug 23, 1915. [Address] 817 Hamilton Terrace

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 4 yrs. 4 mos. 21 ds. In the State 4 yrs. 4 mos. 21 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St. Nebrun DATE OF BURIAL 8/24 1915

20-UNDERTAKER Samuel L. Hays ADDRESS 58 Middle

15- AUG 24 1915
Filed 1915
ROBERT J. KRAUTER,
Burial Permit Clerk
REGISTRAR

C87696

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

77 C87696

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *13th* WARD)2-FULL NAME *William Sullivan*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *3423 Cedar Ave* St. *4* yrs. *4* mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *White* 5-SINGLE MARRIED *Single* WIDOWED OR DIVORCED (Write the word)6-DATE OF BIRTH *Dec* *22* *1910* (Month) (Day) (Year)7-AGE *4* yrs. *0* mos. *0* ds. or min. If LESS than 1 day, hrs.8-OCCUPATION (a) Trade, profession or particular kind of work *none* (b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE (State or country) *md.*

PARENTS	10-NAME OF FATHER <i>William Sullivan</i>
	11-BIRTHPLACE OF FATHER (State or country) <i>md.</i>
	12-MAIDEN NAME OF MOTHER <i>Bessie Chaney</i>
	13-BIRTHPLACE OF MOTHER (State or country) <i>md.</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. J. Smith*(Address) *Johns Hopkins Hosp*

15-AUG 24 1915

ROBERT KRAUTER,

Filed 1915

Municipal Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August* *22* *1915* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *August 20*, 1915, to, *August 22* 1915, that I saw him alive on *August 22* 1915, and that death occurred, on the date stated above, at *10:45 P* m.

The CAUSE OF DEATH* was as follows:

*Septicemia*Contributory (SECONDARY) *Purulent Pericarditis* (Duration) yrs. *7* mos. *7* ds.(Signed) *Oliver S. Rothholz* M. D. *August 22* 1915 (Address) *Johns Hopkins Hosp*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. *2* mos. *2* ds. In the State *md.* yrs. *4* mos. *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *3423 Cedar Ave*19-PLACE OF BURIAL OR REMOVAL *St Marys / Hampden*DATE OF BURIAL *Aug 24 1915*20-UNDERTAKER *Chenoweth & Son*ADDRESS *Chestnut St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87697

C87697

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country)

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

AUG 24 1915

ROBERT J. KRAUTH

Filed

191

BALTIMORE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Aug. 7 1915, to Aug 22 1915

that I saw him alive on Aug 22 1915,

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

Edgar B. Friedman

M. D.

Aug 22, 1915. (Address) 1616 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Registrar.

George J. Smith

707 E. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87698

CERTIFICATE OF DEATH.

78 C87698

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *554 W. Bayre* ST.: *22* WARD)2-FULL NAME *Mutha M. Post*(Residence in Baltimore: No. *554 W. Bayre* St.: *47* yrs., *7* mo., *27* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single
(Write the word.)

6-DATE OF BIRTH

Jan. 27, 1868
(Month) (Day) (Year)

7-AGE

47 yrs., *7* mos., *27* da.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Knitting needle worker

9-BIRTHPLACE, (State or Country)

Baltimore, Md.

10-NAME OF FATHER

Mr. Henry Post

11-BIRTHPLACE OF FATHER (State or Country)

Baltimore

12-MAIDEN NAME OF MOTHER

May Eliza Baugelt

13-BIRTHPLACE OF MOTHER (State or Country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Cornelia A. Vogt*(Address) *1301 Madison Ave.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug. 24, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 20, 1915* to *Aug 24, 1915*, that I saw him alive on *Aug 23, 1915*, and that death occurred, on the date stated above, at *2:30 a.m.*
The CAUSE OF DEATH* was as follows:*Acute Myocarditis*(Duration) *3* yrs., *3* mos., *3* da.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs., *1* mos., *1* da.(Signed) *M. C. Stieglitz* M. D.*Aug 24, 1915* (Address) *612 Columbia Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs., *1* mos., *1* da. In the State *1* yrs., *1* mos., *1* da.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Put Claret Cemetery

DATE OF BURIAL

Aug 27, 1915

UNDERTAKER

George J. Smith

ADDRESS

7401 18th St.

15-

AUG 24 1915

ROBERT J. KRAUTER

Filed

Burial Permit Clerk

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *Mercy Hospital* ST. *4* WARD) REGISTERED No. C
2-FULL NAME *JAMES B. Foreythe*
(Residence in Baltimore: No. *106 N. Green St.* St.; yrs. *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)
6-DATE OF BIRTH *November 23, 1852*
(Month) (Day) (Year)

7-AGE. *62 yrs. 8 mos. 27 ds.* If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Bricklayer*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country), *City*

10-NAME OF FATHER, *Thomas B. Foreythe*

11-BIRTHPLACE OF FATHER (State or Country), *City*

12-MAIDEN NAME OF MOTHER *Fannie C. Buck*

13-BIRTHPLACE OF MOTHER (State or Country), *City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Susan B. Foreythe*
(Address) *106 N. Green St.*

15- AUG 24 1915 ROBERT J. KRAUTER, REGISTRAR.

Filed. 191. MORTAL PERMIT OFFICE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *August 19, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest & autopsy*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest & autopsy*
(Inquest, autopsy or inquiry.)

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accident - Struck by electric car.
Fracture base of skull.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Thos. H. Chambers* M. D.
(Coroner.)

August 13, 1915 (Address) *106 N. Green St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *106 N. Green St.*

19-PLACE OF BURIAL OR REMOVAL, *Not Olcott Cemetery* DATE OF BURIAL, *Aug 24, 1915*

20-UNDERTAKER *Jos. B. Cook* ADDRESS *Baltimore St.*

C87700

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 C87700
REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *424 Belt* ST. *9* WARD)FULL NAME *Edward Lucas West*(Residence in Baltimore: No. *424 Belt* St. yrs. *11* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Caucas.* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 6 DATE OF BIRTH *Unknown*, 19*14*
 7 AGE *11* yrs. *11* mos. ds. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

None

BIRTHPLACE (State or country)

*Balt. Md.*PARENTS
10 NAME OF FATHER*Robt. L. West*

11 BIRTHPLACE OF FATHER (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Agnes Lucas

13 BIRTHPLACE OF MOTHER (State or country)

Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robt. L. West

(Address)

424 Belt St.

15.

AUG 24 1915

Filed

ROBERT L. KRAUTER

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *August 22, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 22*, 1915, to *Aug 22*, 1915, that I saw him alive on *Aug 22*, 1915, and that death occurred, on the date stated above, at *8 P.* m. The CAUSE OF DEATH* was as follows:

Cholera Infantum(Duration) yrs. mos. *2* ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *Edwin K. Ballard* M. D. *Aug 23*, 1915 (Address) *1642 Mt Royal*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. Mary's Cemetery**Aug 24, 1915*

Undertaker

Address

Robt. A. Allard 506 Hogan's Cor.

is very important. See instructions on back of certificate.

C87701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 C87701

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *215-22 1/2*)
2-FULL NAME *Cecil Sterling*
(Residence in Baltimore: No. *215-22 1/2*)

REGISTERED NO. C
ST.: *12* WARD)
(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)
St.; yrs., *6* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>Col</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>Single</i>
6-DATE OF BIRTH, <i>March</i> , <i>1915</i> (Month) (Day) (Year)		
7-AGE, <i>6</i> yrs. mos. ds. If LESS than 1 day, ...hrs. or...min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <i>Infant</i>		
9-BIRTHPLACE, (State or Country), <i>Balt. City</i>		
PARENTS.	10-NAME OF FATHER, <i>Cecil Sterling</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>MD</i>	
	12-MAIDEN NAME OF MOTHER <i>Emma Williams</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>MD</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Cecil Sterling*
(Address) *215-22 1/2 St.*

15-AUG 24 1915
Filed..... 1915
ROBERT KRAUTER
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 23*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*,
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said *inquest*,
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Convulsions
Duration)..... yrs. mos. ds.
CONTRIBUTORY *Gastro Enteritis*
(Secondary) Duration)..... yrs. mos. ds.
(Signed) *James C. Quinn*
(Coroner) *Aug 24 1915* (Address) *3140 Roland Dr*

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Laurel Cemetery*

DATE OF BURIAL, *Aug 24 1915*

20-UNDERTAKER, *Balt. A. Elliott*

ADDRESS *506 Bayview Ave*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *8*)

2-FULL NAME

Residence in Baltimore: No. *1219*

John Hopkins Hospital

William S. Simmons

Durst Alley

St. *24* WARD

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

St.; yrs. *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

White

5-SINGLE

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

July 12th

(Month) (Day) (Year)

7-AGE

1

yrs.

1

mos.

11

ds.

or

min.?

If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Maryland Balto.

PARENTS

10-NAME OF FATHER

John Simmons

11-BIRTHPLACE OF FATHER (State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Emma Koch

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. Roedel

(Address)

John Hopkins Hospital

15-

AUG 24 1915

ROBERT KRAUTER

Bureau of Health

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 23rd

(Month)

(Day)

1915

(Year)

I HEREBY CERTIFY, That I attended deceased from

Aug. 11th, 1915, to, *Aug. 23rd*, 1915,

that I saw him alive on *Aug. 23rd*, 1915,

and that death occurred, on the date stated above, at *12 P.m.*

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion (acute)

(Duration)

mos.

12

ds.

Contributory (SECONDARY)

Bronchitis Pneumonia

(Duration)

yrs.

mos.

3

ds.

(Signed)

Olivia S. Rothko

M. D.

Aug. 23rd, 1915. [Address] *John Hopkins Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place

of death

yrs.

mos.

12

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

1219 Durst Alley

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bedar Hill Cem.

Aug 25th

20-UNDERTAKER

ADDRESS

1039

E. Schloman

Chambers St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. *1* mos. *28* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *June 24, 1915*
(Month) (Day) (Year)7-AGE, *1 mos. 28 ds.* If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE, (State or Country),

In Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

AUG 24 1915

ROBERT E. BRAUTHER
Burial Permit Clerk
Registrar.

16-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

Aug. 24, 1915

17-UNDERTAKER

Martin Fahy & Sons

ADDRESS

606 F. Fayette

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 22, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1st* 1915, to *Aug. 22* 1915, that I saw him alive on *August 22* 1915, and that death occurred, on the date stated above, at *11:45 P. m.* The CAUSE OF DEATH* was as follows:*Malnutrition and*
Malassimilation
(Duration) yrs. *1* mos. *28* ds.

CONTRIBUTORY (Secondary)

(Signed) *Geo. Poulton* M. D.
Aug. 23, 1915 (Address) *615 Belmont Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *28* ds. In the State yrs. *1* mos. *28* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *St. Vincent's Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

Aug. 24, 1915

17-UNDERTAKER

Martin Fahy & Sons

ADDRESS

606 F. Fayette

C87704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 C87704

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.;

WARD)

REGISTERED NO. C

FULL NAME

Prita Foster

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.;yrs. *3* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

*May**22*, 19*15*.
(Month) (Day) (Year)

7-AGE,

yrs. *3* mos. *1* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

AUG. 24 1915

ROBERT

KRAUTER

Filed

M. & T. Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Aug.**23*, 19*15*.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1st* 1915, to *Aug. 22* 1915, that I saw her alive on *Aug. 22* 1915, and that death occurred, on the date stated above, at *8:00 a.m.*

The CAUSE OF DEATH* was as follows:

M. abnutrition and M. ab-assimilation(Duration) yrs. *2* mos. *1* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. *2* mos. *1* ds.(Signed) *J. B. Boulton* M. D.Aug. 23, 1915. (Address) *605 Calumet St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *3* mos. *1* ds. In the State yrs. *3* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *St. Vincent's Inf. Asylum*

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

*Cathedral Cem**Aug. 24, 1915*

20-UNDERTAKER

ADDRESS

*Martin Foley & Sons**606 Lafayette*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 12 yrs., 4 mos. 13 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 11, 1903
(Month) (Day) (Year)

7-AGE,

12

yrs.

4

mos.

10

ds.

If LESS than 1 day,

hrs. or mins.

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer)

Child

9-BIRTHPLACE,
(State or Country),

Balt Md.

10-NAME OF
FATHER,

Frank A Breedew

11-BIRTHPLACE
OF FATHER
(State or Country),

Calvert Co Md

12-MAIDEN NAME
OF MOTHER

Marya Casey

13-BIRTHPLACE
OF MOTHER
(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary A Breedew

(Address)

1439 William St

15-

AUG 24 1915

ROBERT KRAUTER

Filed

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug

21

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from
June 10 1915, to Aug 21 1915,
that I saw him alive on Aug 21 1915,
and that death occurred, on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration)

yrs.

mos.

3

ds.

CONTRIBUTORY
(Secondary)

(Duration)

yrs.

mos.

3

ds.

(Signed)

Jas A. Brown

M. D.

Aug 22, 1915. (Address) 107 E. 7th St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place
of death

yrs.

mos.

ds.

In the
State

yrs.

mos.

ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill Cemetery

Aug 24 1915

20-UNDERTAKER

ADDRESS

Mrs J. H. Evans, Inc.

1428 Charles St.

C87706

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

28

C87706

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1414 Jackson St. 2d WARD)

2-FULL NAME Laura V. Harvey

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1414 Jackson St. 42 yrs. 5 mos. 28 ds.)

St. 42 yrs. 5 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Female

White

Married

6-DATE OF BIRTH

Feb

23, 1873

(Month)

(Day)

(Year)

7-AGE

42 yrs. 5 mos. 28 ds.

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE (State or country)

(Baltimore) Maryland

10-NAME OF FATHER

John Rayner

11-BIRTHPLACE OF FATHER (State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Mary Rayner

13-BIRTHPLACE OF MOTHER (State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry L. Harvey

(Address)

1414 Jackson St.

AUG 24 1915

ROBERT E. KRAUTER

Filed

191

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 21, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20, 1915, to, Aug 21, 1915.

that I saw her alive on Aug 21, 1915.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lung

(Duration) yrs. 2 mos. ds.

Contributory (SECONDARY) Cardiac dilatation

(Duration) yrs. 2 mos. ds.

(Signed) Bidney H. Street M. D.

Aug 23, 1915 (Address) 431 E. Fox Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ledar Hill Cem

Aug 24, 1915

20-UNDERTAKER

ADDRESS

Mrs. J. E. Evans & Sons 1420 E. Charles

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.....

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1114 Ridgely* ST. *21* WARD)

2-FULL NAME *Viola Mary Smith*

(Residence in Baltimore: No. *1114 Ridgely* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

Dec 13 1892

(Month) (Day) (Year)

7-AGE

22 yrs. *8* mos. *9* ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

House duties at home

9-BIRTHPLACE
(State or country)

Balto.

10-NAME OF FATHER

Geo. Hagen

11-BIRTHPLACE OF FATHER
(State or country)

Balto.

12-MAIDEN NAME OF MOTHER

Helen Smith

13-BIRTHPLACE OF MOTHER
(State or country)

Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John W. Smith
1114 Ridgely St.

AUG 24 1915
Filed..... 191

ROBERT K. KRAUTER,
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 22 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY That I attended deceased from *Oct 28* 191*4*, to, *Aug 22* 191*5*.

that I saw h... alive on *Aug 20* 191*5*, and that death occurred, on the date stated above, at *8:30 a.m.*

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory Asthenia

Contributory (SECONDARY) *Pulmonary Emphysema*

(Signed) *F. A. Krause* M. D.
Aug 23 1915 [Address] *18 Randolph St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt. Carmel

DATE OF BURIAL

Aug 25 1915

20-UNDERTAKER

F. A. Krause 703/Haven

HEALTH DEPARTMENT-CITY OF BALTIMORE

C87708

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1531

St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1531

St. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widowed

6-DATE OF BIRTH

November, 1867

7-AGE

48

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE (State or country)

Virginia

10-NAME OF FATHER

Robert Ransom

11-BIRTHPLACE OF FATHER (State or country)

Va.

12-MAIDEN NAME OF MOTHER

Patsy Robinson

13-BIRTHPLACE OF MOTHER (State or country)

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary E. Ransom

(Address)

1531 W. Fairmount Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 22, 1915

17. I HEREBY CERTIFY, That I attended deceased from

Aug 3, 1915, to Aug 23, 1915.

that I saw her alive on Aug 21, 1915.

and that death occurred, on the date stated above, at 8:20 m.

The CAUSE OF DEATH* was as follows:

Malarial Typhoid

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Edward A. Gordon M. D.

Aug 23, 1915 (Address) 750 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt. Auburn Cemetery

DATE OF BURIAL

Aug. 25, 1915

20-UNDERTAKER

George H. Holland

ADDRESS 517 Robert St.

is very important. See instructions on back of certificate.

AUG 24 1915
Filed

Chas M. Suddice

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Md. Gen Hosp.*CITY OF BALTIMORE: (No. ST.: *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Arthur Newton Long*(Residence in Baltimore: No. *729 N. Fayette St.* St.: *2* yrs., *7* mos., *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH.

October 22, 1860
(Month) (Day) (Year)

7-AGE,

*54*yrs., *10* mos., ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Printer

9-BIRTHPLACE, (State or Country),

Harrisonburg, Va.

10-NAME OF FATHER,

Benj. E. Long

11-BIRTHPLACE OF FATHER (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Elizabeth Reher

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

Harrisonburg, Va.

15-

Filed

AUG 24 1915

191

W. H. McQuinn

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 23, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 19* 1915, to *Aug 23* 1915, that I saw him alive on *Aug 22* 1915, and that death occurred, on the date stated above, at *1:15* A.M.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction (Saprophytic)

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

Acute cardiac dilatation
Post-op. Shock (Duration)..... yrs..... mos..... ds.

(Signed).....

J. C. Sumpter, M. D.
723, 1915. (Address) *645 Columbia Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the *2* yrs. *7* mos. *7* ds. State

Where was disease contracted, if not at place of death?

Home

Former or usual residence

729 N. Fayette St.

19-PLACE OF BURIAL OR REMOVAL,

Harrisonburg Va

DATE OF BURIAL,

Aug 25, 1915

20-UNDERTAKER

W. F. McQuinn

ADDRESS

1422 Light

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

356 N. Calvert

ST.

WARD

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Minna Gehr

(Residence in Baltimore: No.

356 N. Calvert

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

August

21, 1887

7-AGE,

48

Yrs. mos. da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Mo.

10-NAME OF FATHER,

Denton S. Gehr

11-BIRTHPLACE OF FATHER

(State or Country),

Mo.

12-MAIDEN NAME OF MOTHER

Annie Light

13-BIRTHPLACE OF MOTHER

(State or Country),

Mo.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm H. Hegdon

(Address)

1001 W. 37th St.

15-

AUG 24 1915

Chas. M. Sinclair

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August

24, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

Chronic endocarditis

(Duration) yrs. mos. da.

(Signed)

Thos. H. Hancock

(Coroner.)

August 24 1915 (Address) 18 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hancock Mt

Aug 25, 1915

20-UNDERTAKER

ADDRESS

Robert J. Turner 1422 W. Broadway

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *917 N. Washington* ST.;

REGISTERED No. C

WARD) *7*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Barbara Lisa(Residence in Baltimore: No. *917 N. Washington* St.;*7* yrs., *6* mos., *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widowed

6-DATE OF BIRTH,

August 19, 1844
(Month) (Day) (Year)

7-AGE,

71 yrs., *—* mos., *—* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife
*Retired*9-BIRTHPLACE,
(State or Country),*Bohemia*

10-NAME OF FATHER,

*Anton Brach*11-BIRTHPLACE OF FATHER
(State or Country),*Bohemia*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Bohemia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anton Brach*(Address) *917 N. Washington*

15-

Filed *AUG 24 1915*

191.

Chas M. Judau
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

August 23, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That attended deceased from *August 19, 1915* to *August 23, 1915*, that I saw her alive on *August 23, 1915*, and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis
(Duration) *—* yrs., *—* mos., *—* ds.*Contributory*
(Secondary) *Inf. of old age*
(Duration) *—* yrs., *—* mos., *—* ds.(Signed) *Chas M. Judau* M. D.
Aug 23, 1915 (Address) *1031 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *—* yrs., *—* mos., *—* ds. In the State *—* yrs., *—* mos., *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

Aug 25, 1915

20-UNDERTAKER

Geo M. Fink

ADDRESS

811 N. Wolfe

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 78 yrs. 7 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow* (Write the word)

6 DATE OF BIRTH *Jan 21, 1837* (Month) (Day) (Year)

7 AGE *78 yrs. 7 mos. 3 ds.* If LESS than 1 day, hrs. or min.?

8 OCCUPATION *None* (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Balt + md.*

10 NAME OF FATHER *Felix Conley*

11 BIRTHPLACE OF FATHER (State or country) *md.*

12 MAIDEN NAME OF MOTHER *Mam*

13 BIRTHPLACE OF MOTHER (State or country) *md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Dr. H. Baker*

(Address) *37 S. Stucker*

15. *Chas. McClain*

Filed *Aug 24 1915* 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Aug. 24, 1915* (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 31, 1915* to *Aug 23, 1915* that I saw him alive on *Aug 23, 1915* and that death occurred, on the date stated above, at *14 m.*

The CAUSE OF DEATH was as follows: *Apoplexy*

Contributory (SECONDARY) *Senile Debility* (Duration) *2* yrs. mos. ds.

(Signed) *John H. Chan* M.D. *Aug 24, 1915* (Address) *Bay & Fayette Sts.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *...* yrs. mos. ds. In the State *...* yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Louisa Park* DATE OF BURIAL *Aug 26, 1915*

20-UNDERTAKER *Joe B. Cook* ADDRESS *1003 N. Baltimore St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Black

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH,

June

27

1898

7-AGE,

17

yrs.

28

mos.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).

Farm Labourer

9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF
FATHER,

Richard Blackwell

11-BIRTHPLACE
OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME
OF MOTHER

Bessie Green

13-BIRTHPLACE
OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

Richard Blackwell

Ellicott City

15-

Filed

AUG 24 1915

191

Chas. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

13-DATE OF DEATH,

(Month)

August

(Day)

24

(Year)

1915

I HEREBY CERTIFY, That I attended deceased from
Aug 21 1915, to Aug 24 1915,
that I saw him alive on Aug 24 1915,
and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Spinal
Myelitis

(Duration)

2

yrs.

2

mos.

2

da.

CONTRIBUTORY
(Secondary)

(Duration)

2

yrs.

2

mos.

2

da.

(Signed) Frank E. Shipley, M. D.
Aug 24, 1915. (Address) Md. Gen. Hosp.*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place
of death

yrs.

mos.

4

da.

In the

State

Md.

Where was disease contracted,
if not at place of death?

Ellicott City

Former or
usual residence

Ellicott City, Md.

19-PLACE OF BURIAL OR REMOVAL,

Ellicott City, Md.

DATE OF BURIAL,

Aug 25, 1915

20-UNDERTAKER

Easton's Sons Ellicott City

ADDRESS:

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 872 Tyson ST.: 11 WARD)

2-FULL NAME

(Residence in Baltimore: No. 872 Tyson St.: 40 yrs., mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE,

Single

6-DATE OF BIRTH,

Oct. 28, 1862
(Month) (Day) (Year)

7-AGE,

50 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer
General9-BIRTHPLACE,
(State or Country).

Md

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER
(State or Country).

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER
(State or Country).

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Leekhelds(Address) 221 E. Chase St.

AUG 25 1915

ROBERT KRAUTER

Filed 1915

Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 23, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1915, to Aug 23, 1915, that I saw him alive on Aug 23, 1915, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Coronary Disease

(Duration) yrs. mos. 23 ds.

CONTRIBUTORY
(Secondary)

Heart Failure

(Duration) yrs. mos. 23 ds.

(Signed)

Charles H. Brown M. D.

Aug 24, 1915 (Address) 7125 Phoebe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Ct

DATE OF BURIAL,

Aug 25, 1915

20-UNDERTAKER

L. L. Brown at Sea 108 m. M. D.

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 S. Collington ST.; 1 WARD)

REGISTERED No. C

2-FULL NAME

Residence in Baltimore: No. 221 S. Collington Ave St.; 60 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed (Write the word.)6-DATE OF BIRTH, Aug. 1, 1839
(Month) (Day) (Year)7-AGE, 76 yrs., 2 mos., ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, none
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, Not known11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER, Not known13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Greenwald(Address) 528 S. Caroline St.

AUG 25 1915

ROBERT . KRAUTER,

Filed....., 191... Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August, 22, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 1, 1915, to August 22, 1915, that I saw him alive on August 22, 1915, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia..... (Duration), 2 yrs., 2 mos., ds.
CONTRIBUTORY (Secondary) Chronic Intestinal Infection..... (Duration) Unknown yrs., mos., ds.(Signed) Wilton P. Hill M. D.Aug. 23, 1915. (Address) Weylin Ave & Park Sts.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs., mos., ds. In the State..... yrs., mos., ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St PaulsDATE OF BURIAL, Aug 26, 1915.20-UNDERTAKER H. Sanders & SonADDRESS 1710 Fleet

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *818. Sarabam* St.: *18* WARD)2-FULL NAME *Boy Gambell*(Residence in Baltimore: No. *818. Sarabam* St.: *Life* yrs. mos. ds.)91 C87716
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *Col*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Infant*6-DATE OF BIRTH, *July 8th, 1915*
(Month) (Day) (Year)7-AGE, *1* yrs. *16* mos. *16* ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Child*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). *Baltimore Md*10-NAME OF FATHER, *Charles Gambell*11-BIRTHPLACE OF FATHER (State or Country). *Baltimore Md*12-MAIDEN NAME OF MOTHER *Eva Cornish*13-BIRTHPLACE OF MOTHER (State or Country). *Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *H. J. Caswell*(Address) *117 N. Calverton*

15-

AUG 25 1915

ROBERT . KRAUTER,

Filed

191

Mortual Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 25th, 1915*
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Aug 21st, 1915* to *Aug 25th, 1915*.that I saw him alive on *Aug 23rd, 1915*and that death occurred, on the date stated above, at *11:50 p.m.*

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(Signed) *H. J. Caswell* M. D.
8/24/15 (Address) *117 N. Calverton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. John's Cemetery*DATE OF BURIAL, *Aug 27th, 1915*

20-UNDERTAKER

*Charles B Jones*ADDRESS *118 N. Calverton*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 C87717
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 Belair Ave. 8 St.)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Herman S. Bertermann

(Residence in Baltimore: No. 2026 Belair Ave.

St.; 58 yrs., \ mos. \ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

Aug 1

(Month)

(Day)

(Year)

7-AGE.

58

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Woodworker

9-BIRTHPLACE.

(State or Country).

Baltimore Md

10-NAME OF FATHER.

Christopher Bertermann

11-BIRTHPLACE OF FATHER

(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Mary Schwarz

13-BIRTHPLACE OF MOTHER

(State or Country).

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Harry Zimmerman

(Address)

1416 N. Gay St.

15-

Filed

AUG 25 1915

ROBERT

KRAUTER

191

MAY 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 25th, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 4 1915, to Aug 25 1915,

that I saw him alive on Aug 24 1915,

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Probably several

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm J. Watson M. D.

Aug 25, 1915. (Address) 2128 St. Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Redeemer Church

Aug 28 1915

20-UNDERTAKER

Henry Horck Sny

ADDRESS

1301 E. Engle St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1528 Homestead* ST.; *9* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1528 Homestead*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *35* yrs., *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

July *28*, *1843*
(Month) (Day) (Year)

7-AGE,

72 yrs., *1* mos., *25* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*nurse*

9-BIRTHPLACE,

(State or Country),

Balls Co. Md.

10-NAME OF FATHER,

Thomas A. Clayton

11-BIRTHPLACE OF FATHER

(State or Country),

Balls Co. Md.

12-MAIDEN NAME OF MOTHER

Rebecca A. Greenfield

13-BIRTHPLACE OF MOTHER

(State or Country),

Balls Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Owen McConnell(Address) *1528 Homestead*

15-

AUG 25 1915

ROBERT

KRAUTER

Filed

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 17, *23*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 17, *1915*, to *Aug 23*, *1915*.that I saw her alive on *Aug 23*, *1915*.and that death occurred, on the date stated above, at *11 P.* m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage(Duration) *1* yrs., *5* mos., *10* ds.

CONTRIBUTORY

(Secondary)

(Duration) *—* yrs., *—* mos., *—* ds.

(Signed)

J. Lee Magnusson M. D.(Address) *1206 S. Preston*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Rose Bank Cemetery Cecil Co., *Aug 26*, *1915*.

20-UNDERTAKER

ADDRESS

*Henry Hoeft Son**1301 E. Eager*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Veronica Koblinski

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. *1* mos. *8* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

May 10, 1915
(Month) (Day) (Year)

7-AGE.

yrs. *3* mos. *13* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.

(State or Country).

Maryland ?

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER (State or Country).

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*

(Address) *1401 Division St.*

15-

AUG 25 1915

ROBERT KRAUTER

BURIAL PERMIT OFFICE

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *August 1st 1915*, to *Aug 23 1915*, that I saw her alive on *August 23 1915*, and that death occurred, on the date stated above, at *3007* m.

The CAUSE OF DEATH* was as follows:

Malnutrition and Mal-assimilation
(Duration) yrs. *1* mos. *8* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. *1* mos. *8* ds.

(Signed)

J. P. Coulson
Aug 24, 1915 (Address) *615 Baltimore St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *8* ds. In the State yrs. *1* mos. *8* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *St. Vincent's Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

New Cathedral

Aug 25, 1915

UNDERTAKER

ADDRESS

John Fields 1200 N. Lombard

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *VV 35 Hennenman* ST.;..... WARD)

2-FULL NAME

(Residence in Baltimore: No. *VV 35 Hennenman* St.:..... yrs., mos. *18 yrs.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-STATUS, *Infant*
(Write the word.)6-DATE OF BIRTH, *Aug 23, 1915*
(Month) (Day) (Year)7-AGE, yrs. mos. da. If LESS than 1 day, *18 hrs. or min.?*8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer). *Infant*9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Harry Lewis*11-BIRTHPLACE OF FATHER (State or Country), *Hartford Conn.*12-MAIDEN NAME OF MOTHER, *Lula Kepler*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry Lewis*(Address) *2235 Hennenman Ave*

15-AUG 25 1915 ROBERT . KRAUTER, Registrar.

Filed..... 191..... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 24, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 23, 1915*, to *Aug 24, 1915*, that I saw her alive on *Aug 24, 1915*, and that death occurred, on the date stated above, at *2 P.M.*

The CAUSE OF DEATH* was as follows:

6 months gestation
Preterm Birth
(Duration)..... yrs. mos. da.

CONTRIBUTORY (Secondary).....

(Signed) *J. E. Horner* M. D.
Aug 24, 1915 (Address) *1201 N. Pat Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Calphons Bern

DATE OF BURIAL,

Aug. 25, 1915

20-UNDERTAKER

Leo. G. Brook

ADDRESS

1106 Patterson Pk Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 3 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word)

Single

6-DATE OF BIRTH,

April 25

1915

(Month)

(Day)

(Year)

7-AGE,

yrs. 3 mos. 29 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE,
(State or Country),

Baltw. Md.

10-NAME OF FATHER,

Charles Noll

11-BIRTHPLACE OF FATHER
(State or Country),

Baltw. Md.

12-MAIDEN NAME OF MOTHER

Theresa Krummel

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltw Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Noll

(Address)

647 Dover st

15-

AUG 25 1915

Filed..... 191

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 24

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 14 1915, to Aug 24 1915,

that I saw him alive on Aug 24 1915,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastric Enteritis

(Duration) yrs. 2 mos. 29 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. 2 mos. 29 ds.

(Signed) Elmer B Freeman M. D.

Aug 25, 1915 (Address) 41 E. Fort St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Olivet Cem

DATE OF BURIAL,

8/26..... 1915

20-UNDERTAKER

J. Frank McGilly

ADDRESS

39 E. Fort St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 Mc Clellan ST.; 14 WARD)2-FULL NAME Amelia Johnston(Residence in Baltimore: No. 832 Mc Clellan St.; 90 yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Col5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Married

6-DATE OF BIRTH.

Unknown, 1
(Month) (Day) (Year)

7-AGE.

90If LESS than 1 day,
..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Mid-wife9-BIRTHPLACE,
(State or Country),Balto. City

10-NAME OF FATHER,

Unknown11-BIRTHPLACE OF FATHER
(State or Country),Unknown

12-MAIDEN NAME OF MOTHER

Mary Donney13-BIRTHPLACE OF MOTHER
(State or Country),Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

John A. Bishop
1107 D. Ave.

15-

AUG 25 1915

Filed....., 191.....

ROBERT J. KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

8/23, 1910.
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from
Jan. 1915 191....., to 8/23 1910,
that I saw him alive on 8/21 1910,
and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Old age + pneumonia
infectedCONTRIBUTORY
(Secondary)Portacel Hemiplegia
Phos. A. L. E. L.
8/25, 1910. (Address) 924 North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Mount Carmel
John A. Bishop
8/25, 1910
8/25

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME

(Residence in Baltimore: No.

St. 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

1. SEX Female 4. COLOR OF RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

6. DATE OF BIRTH

June 16, 1852
(Month) (Day) (Year)

7. AGE

63 yrs. 2 mos. 8 ds. or less than 1 day, hrs. min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or country)

Talbot Co Md

10. NAME OF FATHER

John W. Kelsby

11. BIRTHPLACE OF FATHER

(State or country)

Id -

12. MAIDEN NAME OF MOTHER

Emily Sherman

13. BIRTHPLACE OF MOTHER

(State or country)

Id -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

AUG 25 1915

Filed

191

ROBERT

. BRAUTER,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10. DATE OF DEATH

August 24, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 13, 1914, to Aug 24, 1915.

that I saw her alive on Aug 23, 1915.

and that death occurred, on the date stated above. 4:25 a.m.

The CAUSE OF DEATH* was as follows:

Ataxia Paraplegia

Contributory (SECONDARY)

(Duration) yrs. 10 mos. - ds.

(Signed) Frederick D. Crum M.D.

Aug 24, 1915 (Address) 28270 Calver St

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSE, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Widow Park Cem

DATE OF BURIAL

Aug 26, 1915

20. UNDERTAKER

William Cook

ADDRESS

505 E. 110 Ave

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *324 S. Eyster* ST. *3* WARD)

2-FULL NAME

(Residence in Baltimore: No. *324 S. Eyster St.* St. *2 weeks* yrs. mos. de.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

Sept 19

(Month)

(Day)

(Year)

7-AGE

*45**11**6*

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,

(State or Country).

D. C.

10-NAME OF FATHER.

Michael Barrett

11-BIRTHPLACE OF FATHER

(State or Country)

Ireland

12-MAIDEN NAME OF MOTHER

Bridget Barrett

13-BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

AUG 25 1915

Filed

*ROBERT . KRAUTER**Morial Permit. Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 25

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 12 1915, to *Aug 25 1915*that I saw him alive on *Aug 24 1915*and that death occurred, on the date stated above, at *2:30 p.m.*

The CAUSE OF DEATH* was as follows:

Prig to disease of the kidneys(Duration) *2* yrs. *0* mos. *0* ds.CONTRIBUTORY *Arteriosclerosis*

(Secondary)

Arteriosclerosis of the heart(Duration) *10* yrs. *0* mos. *0* ds.(Signed) *Geo. S. Withers* M. D.*Aug 24, 1915* (Address) *6 N. Bond*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs. *0* mos. *0* ds. In the State *0* yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

*Washington D.C.*DATE OF BURIAL *8/26 1915*

20-UNDERTAKER

Chas. P. Evans & Son 118 W. Mt. Royal Ave

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87725

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (Notation on Certificate) *24* ST. *24* WARD)FULL NAME *Mrs. Max Levy (Pauline Levy)*

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *841 Ducatel St.*St.: *35* yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)

6-DATE OF BIRTH, *Apr. 21, 1887*
(Month) (Day) (Year)

7-AGE, *28* yrs. *4* mos. *3* da. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *Max Levy*
11-BIRTHPLACE OF FATHER (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER, *Pauline Weil*
13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....
(Address).....

15-AUG 25 1915 ROBERT E. KRAUTER, Registrar.
Filed..... 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 24, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 18* 1915, to *Aug 23* 1915, that I saw her alive on *Aug 23* 1915, and that death occurred, on the date stated above, at *7 a.m.*
The CAUSE OF DEATH* was as follows:

Diabetes Mellitus
(Duration)..... yrs. mos. da.

CONTRIBUTORY..... *Pachymia*
(Secondary)
(Duration)..... yrs. mos. da.
(Signed)..... *Edwin S. Davis*..... M. D.
8/24/15 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *26* da. State yrs. mos. da.

Where was disease contracted, if not at place of death? *841 Ducatel St.*

Former or usual residence *841 Ducatel St.*

19-PLACE OF BURIAL OR REMOVAL, *Balto Hebrew* DATE OF BURIAL, *Aug 26, 1915*

20-UNDERTAKER, *David Sandheim* ADDRESS *118 W Mt Prial*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *1336 N. Stricker* ST.: *15* WARD) REGISTERED No. C
2-FULL NAME *Charles Brown*
(Residence in Baltimore: No. *1336 N. Stricker* St.: *19* yrs., — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *Col* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)
6-DATE OF BIRTH, *Apr 17*, 18*75*
(Month) (Day) (Year)

7-AGE, *40* yrs., *4* mos., *4* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Cook*
(b) General nature of industry, business, or establishment in which employed (or employer). *Private Family*

9-BIRTHPLACE, (State or Country). *Md*

PARENTS.
10-NAME OF FATHER. *John Brown*
11-BIRTHPLACE OF FATHER (State or Country). *Md*
12-MAIDEN NAME OF MOTHER. *Louisa Brown*
13-BIRTHPLACE OF MOTHER (State or Country). *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Brown*
(Address) *1336 N. Stricker St.*

15- AUG 25 1915 ROBERT J. KRAUTER, *not* *John*
Filed..... 191..... *1915* *John*
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 22*, 19*15*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 18* 19*15*, to *Aug 22* 19*15*, that I saw him alive on *Aug 22* 19*15*, and that death occurred, on the date stated above, at *11:30 P.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) *5* yrs., *5* mos., *5* ds.

CONTRIBUTORY (Secondary) (Duration) *5* yrs., *5* mos., *5* ds.
(Signed) *Harry Brown* M. D.
Aug 23 19*15* (Address) *1501 Preston St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *not* *John* DATE OF BURIAL, *Aug 25*, 19*15*.

20-UNDERTAKER, *James H. Dennis* ADDRESS *1303 Preston St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

2-FULL NAME

Residence in Baltimore: No. *University Hospital* St. *4* yrs. *10* mos. *10* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Negro*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

1913
(Month) (Day) (Year)

7-AGE,

2 yrs. *10* mos. *10* ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country), *Ind.*

10-NAME OF FATHER,

*Ben. Swander*11-BIRTHPLACE OF FATHER
(State or Country), *Ind.*

12-MAIDEN NAME OF MOTHER

*Judy Isaac*13-BIRTHPLACE OF MOTHER
(State or Country), *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

8/11 1915, to *8/21* 1915,that I saw him alive on *8/21* 1915,and that death occurred, on the date stated above, at *9:15* m.

The CAUSE OF DEATH* was as follows:

*Leuk.**Life*(Duration) *Life* mos. *8* ds.CONTRIBUTORY
(Secondary)(Duration) *Life* yrs. *8* mos. *8* ds.(Signed) *W. H. Miller* M. D.*8/21, 1915* (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *10* mos. *10* ds. In the State *Life* yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *William Sta. - Ind.*

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

UNIVERSITY OF MARYLAND

AUG 24 1915

20-UNDERTAKER

ADDRESS

18-
Filed.....
AUG 25 1915

ROBERT UNRAUTER,

Registrar.

Commissioner Health.

FOR ANATOMICAL PURPOSES

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1725 N. Spring* ST.;REGISTERED NO. C *79*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1725 N. Spring* St.; *71* yrs., *4* mos. *21* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Apr *2*, *1944*
(Month) (Day) (Year)

7-AGE,

71 yrs., *4* mos., *2* ds.If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Landdress*
(b) General nature of industry, business, or establishment in which employed (or employer) *Private Family*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*Jesse Rollins*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Anderson*13-BIRTHPLACE OF MOTHER
(State or Country),*MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Laurel Robinson*(Address) *1725 N. Spring*

15-

AUG 25 1915 ROBERT C. CRAUTER,
Filed Marital Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 23, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May* *1915*, to *August 23 1915*, that I saw *her* alive on *August 22 1915*, and that death occurred, on the date stated above, at *12:15 P.* m.

The CAUSE OF DEATH* was as follows:

*Old Rheumatism**Duration* *1* yrs., *1* mos., *1* ds.CONTRIBUTORY
(Secondary)*Edwards*
(Signed) *Wm. H. White* M. D.*Aug. 24 1915*. (Address) *1161 N. Bway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *71* yrs., *4* mos., *2* ds. In the State *71* yrs., *4* mos., *2* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cem

DATE OF BURIAL,

Aug 25, *1915*.

20-UNDERTAKER

Sam. H. Chase & Son 400 N. Mosher

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE: (No. 87723)

FULL NAME

(Residence in Baltimore: No. 117)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 12.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Sept 27th 1914

7-AGE

11 yrs. 11 mos. ds. or min?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Chief

9-BIRTHPLACE
(State or country)

Baltimore

10-NAME OF FATHER

Wm E. Ront

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Goldie Hale

13-BIRTHPLACE OF MOTHER
(State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. B. Lovett

(Address)

333 Morling Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 23 1915

17-I HEREBY CERTIFY That I attended deceased from Aug 23, 1915, to, Aug 23, 1915

that I saw him alive on Aug 23, 1915, and that death occurred, on the date stated above, at 8:00 p.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

Contributor
(SECONDARY)

(Duration)

yrs

mos

ds

(Duration)

yrs

mos

ds

(Signed)

J. E. Evans, M.D.
8/24, 1915 (Address) 3205 Calhoun

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn

Aug 25 1915

20-UNDERTAKER

ADDRESS

Chenoweth & Co. Chestnut St.

15-

AUG 25 1915

ROBERT J. KRAUTER

Burial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *16* WARD)2-FULL NAME *Major Wilson*(Residence in Baltimore: No. *245 Mountford Ave* St. *unknown* yrs. *unknown* mos. *unknown* ds.)REGISTERED NO. C. *91*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

May

(Month)

12

(Day)

1877

(Year)

7-AGE

38

yrs.

mos.

ds.

If LESS than

1 day, *hrs.*

min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Laborer**General*

9-BIRTHPLACE

(State or country)

md.

PARENTS

10-NAME OF FATHER

Chas. Wilson

11-BIRTHPLACE OF FATHER (State or country)

md.

12-MAIDEN NAME OF MOTHER

Laura Matthews

13-BIRTHPLACE OF MOTHER (State or country)

md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. J. Smith*(Address) *Johns Hopkins Hosp*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August

(Month)

24

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 15, 1915, to August 24, 1915,*that I saw him alive on *August 24, 1915,*and that death occurred, on the date stated above, at *7:30 am.*

The CAUSE OF DEATH* was as follows:

Acute pulmonary edema

(Duration)

yrs.

mos.

1

ds.

Contributory (SECONDARY)

*Myocardial Insufficiency**Brucella pneumonia*

(Duration)

yrs.

mos.

2

ds.

(Signed)

Staubach B. Jones

M. D.

August 24, 1915

[Address]

Johns Hopkins Hosp

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

9

ds.

in the

State

yrs.

mos.

1

ds.

Where was disease contracted, If not at place of death?

Former or usual residence

245 Mountford Ave

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Laurel Cemetery**Aug 25, 1915*

20-UNDERTAKER

Chas. B. Bailey

ADDRESS

Jefferson St

15-

AUG 25 1915

ROBERT KRAUTER

Burial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 W Barre St

ST.; 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Laura J Monks

(Residence in Baltimore: No. 705 W Barre St

St. 52 yrs., 4 mos. 23 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

April 1, 1863
(Month) (Day) (Year)

7-AGE,

52 yrs., 4 mos. 23 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housework at home

9-BIRTHPLACE, (State or Country),

Balto., Md

PARENTS.

10-NAME OF FATHER,

Nicholas Hartman

11-BIRTHPLACE OF FATHER (State or Country),

Balto., Md.

12-MAIDEN NAME OF MOTHER

Matilda Pegg

13-BIRTHPLACE OF MOTHER (State or Country),

Balto., Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hepson (Sister)

(Address) 713 St. Peter st

15-

ROBERT KRAUTER

MARITAL PERMIT OFFICER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 1915, to Aug 24 1915, that I saw her alive on Aug 23 1915, and that death occurred, on the date stated above, at 12 M. D. The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Operation 1 mo previous to death (Duration) yrs. 4 mos. ds.

CONTRIBUTORY Exhaustion (Secondary)

(Duration) yrs. mos. 10 ds.

(Signed) Edwin J. ... M. D.

Aug 24, 1915. (Address) 217 ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mount Olivet Cemetery Aug 27 1915

20-UNDERTAKER

ADDRESS

H. J. M. S. Flynn

1422 Light St

AUG 25 1915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *144 Dolphin* ST.; *11* WARD)

REGISTERED NO. C

2-FULL NAME *William Clark*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *144 Dolphin* St.; *2* yrs., *2* mos., *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. *Male*4-COLOR OR RACE. *Col*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)6-DATE OF BIRTH, *1873*

(Month) (Day) (Year)

7-AGE, *42 yrs.*

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Barber*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *va*10-NAME OF FATHER, *Obv Clark*11-BIRTHPLACE OF FATHER (State or Country), *va*12-MAIDEN NAME OF MOTHER *Luby Clark*13-BIRTHPLACE OF MOTHER (State or Country), *va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). *George A. Williams*(Address). *144 Dolphin St.*

15 AUG 25 1915

ROBERT . KRAUTER,

Filed..... 1915. Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 24*, 19*15*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec. 25* 191*4*, to *Aug. 24* 191*5*, that I saw him alive on *Aug 22* 191*5*, and that death occurred, on the date stated above, at *304*.

The CAUSE OF DEATH* was as follows:

Exhaustion of blood
General debility
of 4 days duration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Complete Hemiplegia*(Signed) *A. Lee Ellis* M. D.*Sept 24* 191*5*. (Address) *724 Madison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt Auburn Cemetery*DATE OF BURIAL, *Aug 27*, 191*5*20-UNDERTAKER, *Felix B Pyle*ADDRESS, *102 E. Mulberry St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. *Patter 64*

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1620 Jefferson* ST.; *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 18.)

2-FULL NAME *Annie K. Patter*(Residence in Baltimore: No. *1620 Jefferson* St.; *life* yrs. *life* mos. *life* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Black*5-STATUS, *Widow**Widow*
(Write the word.)6-DATE OF BIRTH, *Unknown**Unknown*, *1864* (Month) (Day) (Year)7-AGE, *51*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Domestic*(b) General nature of industry, business, or establishment in which employed (or employer), *Private Family*9-BIRTHPLACE, (State or Country), *md.*10-NAME OF FATHER, *Henry Matney*11-BIRTHPLACE OF FATHER (State or Country), *md.*12-MAIDEN NAME OF MOTHER, *Mary Todd*13-BIRTHPLACE OF MOTHER (State or Country), *md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ida Briscoe*(Address) *1620 Jefferson St.*

15-

Filed *9161* *57* *90V* *1915*Registrar. *Chas M. Sinclair*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 23*, *1915*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug. 17*, *1915*, to *Aug. 23*, *1915*, that I saw her alive on *Aug. 23*, *1915*, and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage(Duration) *3* yrs. *1* mos. *5* ds.CONTRIBUTORY (Secondary) *Infantile paralysis*(Duration) *1* yrs. *1* mos. *5* ds.(Signed) *J. C. Robinson* M. D.*Sp. Ch. 15*, *1915* (Address) *611 N. E. Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *1* mos. *5* ds. In the State *1* yrs. *1* mos. *5* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Asbury Cemetery*DATE OF BURIAL, *Aug. 26, 1915*20-UNDERTAKER, *Robert A. Elliott*ADDRESS, *506 Rogers Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87734

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. *6* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *SINGLE*

6-DATE OF BIRTH,

December 12, 1914.
(Month) (Day) (Year)

7-AGE,

8 yrs. *12* mos. *12* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division*

15-

AUG 25 1915
Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 24, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1st* 1915, to *Aug 23* 1915, that I saw her alive on *Aug 23* 1915, and that death occurred, on the date stated above, at *8:00* am.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration)..... yrs. mos. ds.

CONTRIBUTORY. *M. tuberculosis*
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *J. P. Sullivan* M. D.*Aug 24, 1915.* (Address) *615 Columbian*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *6* mos. ds. In the State yrs. *8* mos. *12* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral *Aug 25, 1915.*

20-UNDERTAKER

ADDRESS

M. Fahy & Son 106 Lafayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
Greenmount dead
 CITY OF BALTIMORE (No. *Mercy Hospital*)
 2-FULL NAME *John J. Kurnie*
 (Residence in Baltimore: No. *1325 Carson St.*)

REGISTERED No. C
 ST.: *9* WARD)
 (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-SINGLE, *Single*
 MARRIED, WIDOWED, OR DIVORCED.
 (Write the word.)
 6-DATE OF BIRTH *June 20, 1868*
 (Month) (Day) (Year)
 7-AGE, *50* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Shoe maker.*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
 (State or Country), *Baltimore*

10-NAME OF FATHER, *Andrew Kurnie.*

11-BIRTHPLACE OF FATHER (State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER *Annie Kirby.*

13-BIRTHPLACE OF MOTHER (State or Country), *Ireland.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Bessie Kurnie (Sister)*
 (Address) *1325 Carson St.*

15- *Aug 25 1915*

Chas M Sinclair
 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 24, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* find that said deceased came to *death* (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:
apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *arterio sclerosis*

(Duration) yrs. mos. ds.

(Signed) *Thos H Chambers* M. D.
 (Coroner)
August 24, 1915 (Address) *15 W Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Greenmount* DATE OF BURIAL, *Aug 26*, 19....

20-UNDERTAKER *John J. Foley & Sons* ADDRESS *1318 Light*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. *Hummelheber*

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. *1945 W. Franklin* ST.; *20* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Marion Roselo Hummelheber*(Residence in Baltimore: No. *1945 W. Franklin* St. *39* yrs., *1* mos. *21* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

July 4, 1856
(Month) (Day) (Year)

7-AGE,

*59*yrs., *1* mos., *21* da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*house work*
at home

9-BIRTHPLACE, (State or Country),

W. Va.

10-NAME OF FATHER,

Richard Pomeroy

11-BIRTHPLACE OF FATHER (State or Country),

unknown

12-MAIDEN NAME OF MOTHER

Mary K. Coskey

13-BIRTHPLACE OF MOTHER (State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Raymond H. Scott

(Address)

927 W. Mulberry

15-

Filed

1915

Chas. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

aug 28, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 16, 1914 to *aug 28, 1915*that I saw her alive on *aug 24, 1915*,and that death occurred, on the date stated above, at *3 a.* m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis(Duration) *3* yrs., *1* mos., *21* da.CONTRIBUTORY (Secondary) *nutritional degeneration*(Signed) *Geo. H. Smarr* M. D.*8/28, 1915* (Address) *Franklin St. 20*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. *21* da. In the State *39* yrs. mos. da.Where was disease contracted, if not at place of death? *unknown*Former or usual residence *1945 W. Franklin St.*

19-PLACE OF BURIAL OR REMOVAL,

Martinsburg W. Va.

20-UNDERTAKER

George J. Smith

DATE OF BURIAL,

Aug. 28, 1915

ADDRESS

1000 1st St.

AUG 25 1915

C87737

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 C87737
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 116 8 W Hamburg

ST. 21

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry John Schultz Jr.

(Residence in Baltimore: No. 116 8 W Hamburg St.

St. yrs. 4 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6-DATE OF BIRTH April 13, 1915
(Month) (Day) (Year)

7-AGE 4 yrs. 12 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Balto. Md.

10-NAME OF FATHER Henry J. Schultz

11-BIRTHPLACE OF FATHER (State or country) Balto. Md.

12-MAIDEN NAME OF MOTHER Eliz. Musch.

13-BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter C. Bacon

(Address) Garrett Hospital

15. AUG 25 1915 Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug 25, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 31, 1915, to Aug 25, 1915, that I saw him alive on Aug 25, 1915, and that death occurred, on the date stated above, at 5 A. M. The CAUSE OF DEATH* was as follows:

Elio Colitis

Contributory (SECONDARY) Cardiac failure (Duration) yrs. 1 mos. 25 ds.

(Signed) Walter C. Bacon M.D. 8/25, 1915 (Address) Garrett Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park

DATE OF BURIAL Aug 26, 1915

20-UNDERTAKER

ADDRESS

Mrs. Mrs. M. N. Leupel 801 St. Fayette

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from April 24 1915 to Aug 25 1915, that I saw him alive on Aug 25 1915, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Elementary Intoxication
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. B. Friederwald M. D.

Aug 25, 1915 (Address) 1616 Linden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1024 Sharp* ST. *23* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1024 Sharp* St.; *Life* mos. da)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Aug. 11, 191*8*
(Month) (Day) (Year)

7-AGE,

1 yrs. *13* mos. *13* da.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...*None*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*Rudolf E. Witte*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore*

12-MAIDEN NAME OF MOTHER

*Ethel Baitzel*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rudolf E. Witte*(Address) *1024 S. Sharp St.*

15-

Filed *Aug 25 1915*

191

Charles M. Sweeney
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 24, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 23* 191*5*, to *Aug 24* 191*5*, that I saw her alive on *Aug 24* 191*5*, and that death occurred, on the date stated above, at *70* m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum(Duration) *2* mos. *2* ds.CONTRIBUTORY
(Secondary)(Duration) *1* mos. *1* da.(Signed) *Shelton* M. D.*Aug 25*, 191*5*. (Address) *1228 S. Sharp St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Rev. Olivet Cem.

DATE OF BURIAL,

Aug 26 1915

20-UNDERTAKER

*S. Schloman & Son*ADDRESS *1039**Harvard St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2706 Guilford Ave. ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys Hendricks

(Residence in Baltimore: No. 2706 Guilford Ave. St.; - yrs., 2 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)

Single

6-DATE OF BIRTH.

July 29, 1911
(Month) (Day) (Year)

7-AGE.

4

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE,
(State or Country).

New York City

PARENTS.

10-NAME OF FATHER.

Robert J. Hendricks

11-BIRTHPLACE OF FATHER
(State or Country).

N.Y.

12-MAIDEN NAME OF MOTHER

Helen Meedly

13-BIRTHPLACE OF MOTHER
(State or Country).

N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robt J. Hendricks

(Address)

2706 Guilford Ave

15-

Filed

1915

C. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

August 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 23, 1915, to Aug 24, 1915,

that I saw her alive on Aug 24, 1915,

and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Exanthematous Erythema
Septicemia

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. S. S. M. D.

Aug 25, 1915. (Address) 2877 Calumet St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Western Cemetery Aug 27, 1915.

20-UNDERTAKER

William C. Cook 507 E. N. Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *509 Melrose Alley* ST.; *22* WARD)

2-FULL NAME

(Residence in Baltimore: No. *509 Melrose Alley* St.; *51* yrs., mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*Col*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

6-DATE OF BIRTH,

Jan 1864
(Month) (Day) (Year)

7-AGE,

51

yrs. mos. ds.

If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic
Laundress work

9-BIRTHPLACE, (State or Country),

N.Y. Balto.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Martha Wilson

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

George Brown
618 Warner St

AUG 26 1915

ROBERT . KRAUTER,

Filed....., 191...
Registral Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

8 *23*, 1915.
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Aug 16* 1915, to *Aug 23* 1915, that I saw her alive on *Aug 23* 1915, and that death occurred, on the date stated above, at *90* m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pericarditis

(Duration)..... yrs. mos. ds.

(Signed)

G. G. Whipple
Aug 23, 1915. (Address) *424 East 23 St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn Ct

DATE OF BURIAL,

Aug 26, 1915.

20-UNDERTAKER

S. L. Brown & Son

ADDRESS

108 W. Montg

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1005 China*)ST.: *21* WARD)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME *Leroy Jenkins*(Residence in Baltimore: No. *1005 China*)St.; *5* yrs., *5* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *March 24, 1915*
(Month) (Day) (Year)7-AGE, *5* yrs., *5* mos., *—* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Balto Md*10-NAME OF FATHER, *Cephus Jenkins*
11-BIRTHPLACE OF FATHER (State or Country), *Md*12-MAIDEN NAME OF MOTHER *Hattie Wilson*13-BIRTHPLACE OF MOTHER (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hattie Jenkins (mother)*(Address) *1005 China St*15-*AUG 26 1915* ROBERT KRAUTER, Registrar.
Filed *1915* Burial *Permie Clark*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 24, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased *on*
Aug 24 1915, to *191*,
that I saw her alive on *Aug 24* 1915,
and that death occurred, on the date stated above, at *8:30 p. m.*

The CAUSE OF DEATH* was as follows:

Euteria colitis..... (Duration) *X* yrs., *—* mos., *2* ds.
CONTRIBUTORY (Secondary) *Cardiac Failure*..... (Duration) *—* yrs., *—* mos., *—* ds.
(Signed) *E. D. Ellis* M. D.
Aug 25 1915. (Address) *915 Light St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *—* yrs., *—* mos., *—* ds. In the State *—* yrs., *—* mos., *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *mt auburn ct*DATE OF BURIAL, *Aug 27, 1915*20-UNDERTAKER, *J. B. Brown & Son*ADDRESS, *108 W. Montz St*

C87743

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland Penitentiary* ST. *10* WARD)2-FULL NAME *Walter Booge*(Residence in Baltimore: No. *Maryland Penitentiary* St. *1* yrs. *4* mos. *15* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

April- 3, 1886
(Month) (Day) (Year)

7-AGE

29 yrs. *4* mos. *16* ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer).*Farmer**Laborer*9-BIRTHPLACE
(State or country)*Montgomery County*

10-NAME OF FATHER

*James Booge*11-BIRTHPLACE OF FATHER
(State or country)*Maryland*

12-MAIDEN NAME OF MOTHER

*Laura Johnson*13-BIRTHPLACE OF MOTHER
(State or country)*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John H. Smith
(Address) *Md. Penitentiary*

AUG 26 1915

ROBERT . KRAUTER,

Filed

191

MORIAL PENITENTIARY

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August- 19, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*March 19, 1915, to August 19, 1915,*that I saw him alive on *August- 18, 1915,*and that death occurred, on the date stated above, at *6:30 A.M.*

The CAUSE OF DEATH* was as follows:

*Toxemia and Exhaustion*Contributory (SECONDARY) *Pulmonary Tuberculosis*
(Duration) yrs. mos. *14* ds.*osis* (Duration) yrs. mos. *5* ds.(Signed) *William F. Schwartz* M.D.*August 19, 1915* [Address] *Md. Penitentiary*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *1* yrs. *4* mos. *15* ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence *Rockville Md.*

19-PLACE OF BURIAL OR REMOVAL

Southsburg Md.

DATE OF BURIAL

Aug 26, 1915

20-UNDERTAKER

W. J. Sicken & Sons ADDRESS *Camden River Hts*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *906 E Pratt* ST.; *3* WARD)

2-FULL NAME

(Residence in Baltimore: No. *906 E Pratt* St.; *65* yrs., *3* mos. *23* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

AUG 26 1915

ROBERT . KRAUTER,

Filed

191

BALTIMORE PUBLIC HEALTH REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on and that death occurred, on the date stated above, at 8 p. m.
The CAUSE OF DEATH* was as follows:Cardiac & Respiratory
ParalysisCONTRIBUTORY
(Secondary)

(Signed) P. Wallensten M. D.

Aug 25, 1915. (Address) 6 S Exeter St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Mary Hospital*)ST. *2*

WARD

REGISTERED No. C

FULL NAME

Joseph Collier
229 S. Broadway(Residence in Baltimore: No. *229 S. Broadway*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *1* mos. *7* ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

Single

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

*August**1893*

(Month)

(Day)

(Year)

7-AGE,

22

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

clerk

(b) General nature of industry, business, or establishment in which employed (or employer).

Paint-store

9-BIRTHPLACE,

(State or Country),

Austria

10-NAME OF FATHER,

Benj. Collier

11-BIRTHPLACE OF FATHER

(State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Lara Yeggerman

13-BIRTHPLACE OF MOTHER

(State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *David Collier (Brother)*(Address) *1311 E. Baltimore St.*

15-

Filed

AUG 26 1915

ROBERT

KRAUTER

Bureau of Health

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

August

(Month)

25, 1915

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

Inquest

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

*Accident - Burns of Body & extremities**Shock - Clothing accidentally**catching fire* (Duration) *9* yrs. *7* mos. *25* ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. Frank

(Coroner.)

M. D.

August 25

1915.

(Address)

*18**W. Frank**St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

9 hours

of death

yrs.

mos.

ds.

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

*1310 E. Baltimore St.*Former or usual residence *229 S. Broadway*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Heaven Mt. Cemetery**Aug 26, 1915*

20-UNDERTAKER

ADDRESS

*Jack Lewis**1419 E. B. St.*

important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. ST. WARD) 64

2-FULL NAME

(Residence in Baltimore: No. St. yrs. mos. ds.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or country)

PARENTS

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I attended deceased from

that I saw h. alive on 191...., to 191....,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

Aug 24, 191....

[Address]

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificate.

15-

AUG 26 1915

ROBERT J. KRAUTER

Municipal Permit Clerk

REGISTRAR

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2429 Hait Ave ST. 1 WARD)2-FULL NAME George H. Frederick(Residence in Baltimore: No. 2429 Hait Ave St. Life yrs., mos., ds.)REGISTERED NO. C 104 87747

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Feb.8th1915

(Month)

(Day)

(Year)

7-AGE,

615

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Balto. City Md

10-NAME OF FATHER,

Frederick Frederick

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Elonora Leuz

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elonora Frederick(Address) 2429 Hait Ave

15-

AUG 26 1915

ROBERT

KRAUTER,

Filed

101

Certified

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August25th1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 171915, to Aug 241915that I saw him alive on Aug 241915and that death occurred, on the date stated above, at 100 m.

The CAUSE OF DEATH* was as follows:

Exhaustion (Toxemia)1 week

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

Cholera InfantumIndefinite

(Duration)

yrs.

mos.

ds.

(Signed) J. Albert Miller

M. D.

8/25/15

1915

(Address) 2723 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

1st Evangelical Ch.Aug. 27, 1915

20-UNDERTAKER

ADDRESS

H. Sander son1710 Fleet St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *643 Sterling*)

FULL NAME *Irene J. Clark*

(Residence in Baltimore: No. *643 Sterling*)

REGISTERED No. C

ST. *5*

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)

6-DATE OF BIRTH, *July 7th, 1888* (Month) (Day) (Year)

7-AGE, *27* yrs. *0* mos. *17* ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Housework* (b) General nature of industry, business, or establishment in which employed (or employer), *at home*

9-BIRTHPLACE, (State or Country), *Balto Md*

10-NAME OF FATHER, *Louis J. Clark*

11-BIRTHPLACE OF FATHER, (State or Country), *Ta*

12-MAIDEN NAME OF MOTHER, *Mary E Snowden*

13-BIRTHPLACE OF MOTHER, (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Yates*

(Address) *643 Sterling St*

15- *AUG. 26 1915* ROBERT J. BRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 24th, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (?)

(Duration) *1* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

(Signed) *Elyah J. Russell* M. D. (Coroner.)

Aug 24, 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Asbury Cemetery Aug 27, 1915*

20-UNDERTAKER, ADDRESS *H. E. Gross 1400 Mt. Vernon St*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 Bolton St ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Frew Smyth(Residence in Baltimore: No. 1206 Bolton St St.; 00 yrs., ? mos., ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widowed6-DATE OF BIRTH, July 14 1829, 1 (Month) (Day) (Year)7-AGE, 86 yrs., 1 mos., 11 ds. If LESS than 1 day,hrs. or....min.8-OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Ireland10-NAME OF FATHER, John Frew11-BIRTHPLACE OF FATHER (State or Country), Ireland12-MAIDEN NAME OF MOTHER, Frew Thillewaite13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth A. Smyth(Address) 1206 Bolton St

15- AUG 26 1915 ROBERT KRAUTER, 191. Burial Permit. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 25, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from August 24, 1915, to Aug. 24, 1915, that I saw him alive on Aug. 24, 1915, and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

CONTRIBUTORY (Secondary)

(Duration)yrs.mos.ds.

(Signed) E. B. Brashley M. D.Aug. 25, 1915 (Address) 1206 Bolton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park CemeteryDATE OF BURIAL, Aug. 27, 191520-UNDERTAKER, Stewart Mowin CoADDRESS, 108 W North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87750

C87750

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

AUG 26 1915

Filed....., 191

ROBERT J. KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from Aug 13 1915, to Aug 25 1915, that I saw her alive on Aug 24 1915, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis
2 weeks was at HarpCONTRIBUTORY Capillary Bronchitis
(Secondary)(Signed) J. H. G. Smith M. D.
Aug 26, 1915 (Address) 1025 N. Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 3533 Falls Road

ST. 13 WARD

FULL NAME William H. Harp

(If death occurred in a hospital or institution, give the NAME instead of street and number and R.N. No. 10.)

(Residence in Baltimore: No. 3533 Falls Road

L110 St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male	4-COLOR OR RACE White	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married
6-DATE OF BIRTH Dec 9 1853 (Month) (Day) (Year)		
7-AGE 61 yrs. 8 mos. 15 ds. or min.? If LESS than 1 day, hrs.		
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Railroad Conductor		

9-BIRTHPLACE
(State or country)

Maryland Balto.

PARENTS

10-NAME OF FATHER	Harp
11-BIRTHPLACE OF FATHER (State or country)	Maryland
12-MAIDEN NAME OF MOTHER	Mary Ayler
13-BIRTHPLACE OF MOTHER (State or country)	Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ida Harp

3533 Falls Road

(Address)

AUG 26 1915

Filed 191

ROBERT J. ZRAUTNER
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

Aug 24 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1915, to Aug 24 1915, that I saw him alive on Aug 24 1915, and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Contributory
(SECONDARY)

(Duration) 3 yrs + mos. ds.

(Duration) 1 yrs 6 mos. ds.

(Signed) R.B. Norman M.D.
Aug 26 1915 [Address] 3147 Chestnut St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

Aug 26 1915

20-UNDERTAKER

ADDRESS

A.S. Marshall

3539 Falls Road

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (NO.

FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address)

15-

AUG 26 1915

ROBERT . KRAUTER,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema (Manslaughter) Fractured Scapula

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. J. Jeffers M. D.

Aug 26 1915 (Address) 413 N. Carrollton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 132 Augusta Ave

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

John J. Coonan 901 Hollister

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1506 N. Fulton St. 15 WARD)

2-FULL NAME John R. Youngman

(Residence in Baltimore: No. 1506 N. Fulton Ave

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Aug 4

1827

(Month)

(Day)

(Year)

7-AGE,

87

9

21

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Grace

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Unknown

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John M. Youngman

(Address)

2449 Woodstock Ave

15-

AUG 26 1915

ROBERT J. KRAUTER,

Filed

191

Marshall P. Parole Mark

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug

25

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 18 1915, to Aug 25 1915,

that I saw him alive on Aug 25 1915,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Bacterial Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Leonard E. Beach M. D.

Aug 26, 1915. (Address) 1 E. 21st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park

Aug 27, 1915

20-UNDERTAKER

ADDRESS

John Cook

502 E. No. 4

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 087754
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Rutland ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Martha V. Jackson(Residence in Baltimore: No. 1013 Rutland aveSt.; 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Nov 24, 1856
(Month) (Day) (Year)

7-AGE,

58 yrs. 9 mos. ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

At home9-BIRTHPLACE,
(State or Country),Md.

10-NAME OF FATHER,

Charles W. Willey11-BIRTHPLACE OF FATHER
(State or Country),Md.

12-MAIDEN NAME OF MOTHER,

Susanah Sewell13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Greenbury M. Jackson(Address) 1013 Rutland ave

15

AUG 26 1915ROBERT . KRAUTER,Filed 1915 Aug 26 1915 1013 Rutland ave
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 24, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Apr 16 1915, to Aug 24 1915, that I saw her alive on Aug 24 1915, and that death occurred, on the date stated above, at 11.45 P.M.
The CAUSE OF DEATH* was as follows:Carcinoma of Uterus and
Pelvic Organs. (Operation)
(Duration) 1 yrs. mos. ds.CONTRIBUTORY
(Secondary)(Signed) Walter W. White M. D.
Aug 26, 1915. (Address) 1101 13th ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore County

DATE OF BURIAL,

Aug 27, 1915

20-UNDERTAKER

Girkler & Girkler

ADDRESS

1739 E. Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124-N Mount St. WARD) 104

2-FULL NAME

Residence in Baltimore: No. 124-N. Mount

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 1 yrs. 1 mos. 28 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 29, 1915

(Month)

(Day)

(Year)

7-AGE,

1 yrs. 1 mos. 28 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

AUG 26 1915

ROBERT . KRAUTER

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 26, 1915

(Month) 26

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 22 1915, to Aug 25 1915, that I saw her alive on Aug 25 1915,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum
2 days

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute nephritis

(Duration) yrs. mos. ds.

(Signed) J. H. Stated M. D.

8/26/15 (Address) 124-N. Mount St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

St. Oliver Cemetery

Aug. 27, 1915.

20-UNDERTAKER

Harry A. Witke

ADDRESS

1534 W. Lombard St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Nos. 19* ST. *19* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *Kennedyville md* St. *36* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (8).)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, ?

(Month)

(Day)

(Year)

7-AGE,

*36**1**2*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

unknown

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Franklin Sq. Nos. 19*(Address) *Sanck*

15-

Filed

191

Chas M Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

aug 25

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *aug 23* 191*5*, to *aug 25* 191*5*; that I saw her alive on *aug 25* 191*5*; and that death occurred, on the date stated above, at *7:30 P. m.*

The CAUSE OF DEATH* was as follows:

degenerative Sarcoma of uterus operated on Aug 25

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Stroke (Duration) yrs. mos. ds.(Signed) *Geo. G. Gann* M. D.*8/26*, 191*5* (Address) *Franklin Sq. Nos. 19*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. *3* ds. In the State yrs. mos. ds.Where was disease contracted if not at place of death? *at Home*Former or usual residence *Kennedyville md.*

19-PLACE OF BURIAL OR REMOVAL,

Chestertown Md

DATE OF BURIAL,

Aug. 26, 191*5*

20-UNDERTAKER

Stewart Mowen Co

ADDRESS

108 W. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *1* WARD)

REGISTERED NO. C.....

2-FULL NAME

(Residence in Baltimore: No. *3123 Foster Ave.* St. *15* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Filed.....

191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

.....*August*.....*26*....., 191*5*.
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
.....*August 14* 191*5*, to *August 26* 191*5*,
that I saw h *22* alive on *August 26* 191*5*,
and that death occurred, on the date stated above, at *6 a.m.*

The CAUSE OF DEATH* was as follows:

.....*Strangled Umbilical*
.....*Asphyxia*.....CONTRIBUTORY
(Secondary).....*about 6 hrs.*.....
(Duration).....yrs.....mos.....ds.(Signed).....*J. W. Vinton Cliff*.....M. D......*August 26* 191*5*. (Address).....*St. Joseph's Hospital*.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. *12* ds. In the *60* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *3123 Foster Ave.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

.....*Sacred Heart Cemetery*.....*Aug 30* 191*5*.

20-UNDERTAKER

ADDRESS

.....*Lilly Zeiler*.....*403. S. Maple*

HEALTH DEPARTMENT—CITY OF BALTIMORE

87753

CERTIFICATE OF DEATH.

30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 E. Chase St.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number; and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1917 E. Chase St. life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

October 25, 1914
(Month) (Day) (Year)

7-AGE,

10 yrs. 10 mos. ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Baltimore City

10-NAME OF FATHER,

Samuel Volpe

11-BIRTHPLACE OF FATHER
(State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Mary Fania

13-BIRTHPLACE OF MOTHER
(State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Volpe

(Address) 1917 E. Chase St.

15-

Filed

1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 25th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 15, 1915, to Aug. 25, 1915,

that I saw him alive on Aug. 24, 1915,

and that death occurred, on the date stated above, at 9⁰⁰ m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

..., 191... (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Vincent's Cem.

DATE OF BURIAL,

Aug. 26, 1915

20-UNDERTAKER

Lilly & Co. Filson

ADDRESS

403 S. Wolfe

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *300 & Norris* ST.; *19* WARD)

REGISTERED NO. C

2-FULL NAME *Louis Guirak*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *300 & Norris* St.; *1* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*4-COLOR OR RACE, *White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *July 24, 1915*

(Month)

(Day)

(Year)

7-AGE, *1* yrs. *1* mos. *1* ds.If LESS than 1 day, *1* hrs. or *1* min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Austria Balt Md*10-NAME OF FATHER, *George Guirak*11-BIRTHPLACE OF FATHER (State or Country), *Austria*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *George Guirak*(Address), *300 & Norris St*

15-

Filed *1915*

191

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 25th, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug. 16th, 1915*, to *Aug. 24th, 1915*that I saw him alive on *Aug 24th, 1915*and that death occurred, on the date stated above, at *10:30 P.M.*

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) *Gastro-enteritis*

(Duration)..... yrs..... mos..... ds.

(Signed) *M. Kahn* M. D.*Aug. 26th, 1915* (Address) *677 Columbia St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *St. Peter's Cemetery*DATE OF BURIAL, *Aug. 27, 1915*20-UNDERTAKER, *John J. Fields*ADDRESS *1207 N. Lombard St*

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87760

CERTIFICATE OF DEATH

105

C87760

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

1510 N. Washington St.

WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Wester Ann Ness

(Residence in Baltimore: No.

1510 N. Washington

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

April

16

1894

(Month)

(Day)

(Year)

7 AGE

74

yrs.

4

mos.

8

ds.

If LESS than

1 day, hrs.

or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Baltimore

10 NAME OF FATHER

Wm Constantine

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Lena Burke

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo B Ness

(Address)

1510 N Washington

B 1915

Filed

191

Charles M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 24

1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 17

1915

to May 24

1915

that I saw him alive on

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Supination of age

Contributory (SECONDARY)

(Signed)

May 24

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Loudon Park

DATE OF BURIAL

Aug 27, 1915

20 UNDERTAKER

Henry Lutz

ADDRESS

1007 N. Bond

State CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Prot. Infirmary* ST. *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mr. W. B. Powell*(Residence in Baltimore: No. *2904 Allendale Road* St. *20* yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, ~~MARRIED~~ *Married*
WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *Jan* *18*, *1885*
(Month) (Day) (Year)7-AGE, *30* yrs. *7* mos. *8* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Baltimore*PARENTS.
10-NAME OF FATHER, *Mr. Connell*
11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*
12-MAIDEN NAME OF MOTHER, *Florence B. Lane*
13-BIRTHPLACE OF MOTHER (State or Country), *Pa*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. W. Powell*
(Address) *2904 Allendale Road*15- *Chas M. Sinclair*
Filed *26* 191*5* 191. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug* *26*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug. 16* 191*5*, to *Aug. 26* 191*5*, that I saw her alive on *Aug. 26* 191*5*, and that death occurred, on the date stated above, at *5* a. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis
.....
.....
..... (Duration) *2* yrs. mos. ds.CONTRIBUTORY *Relapsing* *Cholera*
(Secondary) *Cholera* (Duration) yrs. mos. ds.
(Signed) *James S. Chaffee* M. D.
Aug. 26, 1915. (Address) *Dr. R. S.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. *11* ds. In the State *30* yrs. mos. ds.Where was disease contracted, if not at place of death? *2904 Allendale Road*Former or usual residence *2907 Allendale Road, Baltimore*19-PLACE OF BURIAL OR REMOVAL, *London Park* DATE OF BURIAL, *Aug. 28* 191*5*20-UNDERTAKER *W. B. Powell* ADDRESS *1725 W. Lafayette Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1228 N. Calvert ST. 11 WARD)

REGISTERED NO. C.....

2-FULL NAME Ariana F. Bruscoe

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1228 N. Calvert Street St.; 84 yrs., 4 mos., 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Married (If Widowed, fill in the word.)6-DATE OF BIRTH, April 11th, 1831 (Month) (Day) (Year)7-AGE, 84 yrs., 4 mos., 15 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Maryland

PARENTS.	10-NAME OF FATHER, <u>James Polk</u>
	11-BIRTHPLACE OF FATHER (State or Country), <u>Maryland</u>
	12-MAIDEN NAME OF MOTHER, <u>Anne M. Polk</u>
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Maryland</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nathan R. Gorton
(Address) 1 W. Biddle St.15-Aug 26 1915
Filed 26 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 26th, 1915. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 14th 1915, to Aug. 25th 1915, that I saw her alive on August 25th 1915, and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:

General Carcinoma
(Carcinoma uteri & rectum)
(Primary cause)(Duration) 8 yrs., 8 mos., 8 ds.
Autopsy made - no microscopic
CONTRIBUTORY by secondary carcinoma
(Secondary) of uterine carcinoma
(Duration) 8 yrs., 8 mos., 8 ds.(Signed) Nathan R. Gorton M. D.
Aug. 26th 1915. (Address) 1 W. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, 84 yrs., 4 mos., 15 ds. In the State MD yrs., 4 mos., 15 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Millidgeville Georgia DATE OF BURIAL, Aug. 28th, 1915.
20-UNDERTAKER, Henry Jenkins & Co ADDRESS 1000 E. Pratt St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Md. General Hospital ST., 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Hodges(Residence in Baltimore: No. 1406 Hollins St. St.; 57 yrs., 8 mos., 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

Dec. 18, 1857
(Month) (Day) (Year)

7-AGE,

57 yrs., 8 mos., 5 ds.

IF LESS than 1 day,

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Unkown13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophia Chelgast(Address) 1315 N. Central

15-

Filed AUG 26 1915Chas M. Sicular
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 25, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 22 1915, to Aug 25 1915,that I saw her alive on Aug 25 1915,and that death occurred, on the date stated above, at 2:45 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure(Duration) 2 yrs., 2 mos., 2 ds.CONTRIBUTORY Broncho Pneumonia
(Secondary)(Duration) 4 yrs., 3 mos., 3 ds.(Signed) Frank E. S. Bradley, M. D.Aug. 25, 1915 (Address) Md. Genl. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs., 4 mos., 5 ds. In the State 1915Where was disease contracted, if not at place of death? 1406 Hollins St.Former or usual residence 1406 Hollins St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Howden Paul Cem Sept 8, 1915

20-UNDERTAKER

ADDRESS

Geo J. Smith 1000 Taylor St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

St.; 60 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widow

6-DATE OF BIRTH

November 25, 1838

7-AGE

76 yrs. 8 mos. 30 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Germany

10-NAME OF FATHER

not known

PARENTS

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Wm. J. Dixon

(Address)

3203 Stafford St

15.

Filed AUG 26 1915

Blisselaw
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug. 24, 1915

17. I HEREBY CERTIFY, That I attended deceased from

abt July 1915, to, Aug 24 1915.

that I saw her alive on Aug 24, 1915.

and that death occurred, on the date stated above, at 11:40 pm.

The CAUSE OF DEATH* was as follows:

Cancer
Gall Bladder
Clinical Diagnosis

(Duration) Aug 9 yrs. 9 mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Wm. D. L. M. D.
Aug 25, 1915 (Address) 3310 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Landon Park Cemetery

DATE OF BURIAL

Aug 27, 1915

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 W. Baltimore St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *University Hosp* ST. *4* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *University Hosp* St. *4* yrs. *1* mos. *1* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED,

Married
(Write the word.)

6-DATE OF BIRTH,

8.6.68
(Month) (Day) (Year)

7-AGE,

49
yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),*Va*

10-NAME OF FATHER,

*John Brown*11-BIRTHPLACE OF FATHER
(State or Country),*Va*

12-MAIDEN NAME OF MOTHER

*Martina Brown*13-BIRTHPLACE OF MOTHER
(State or Country),*Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. S. Coleman M.D.*(Address) *University Hosp*

15-

Filed *AUG 26 1915**Geo M. Duclair*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 25, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 22 191*5*, to *Aug 25* 191*5*,that I saw him alive on *Aug 25* 191*5*,and that death occurred, on the date stated above, at *11:20* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate
G. B. L. & Co.(Duration) *2* yrs. *1* mos. *1* ds.CONTRIBUTORY
(Secondary)*Acute dilatation*
Shonash (Duration) *1* yrs. *1* mos. *1* ds.(Signed) *A. S. Coleman* M. D.*Aug 25*, 191*5*. (Address) *University Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *4* yrs. *1* mos. *1* ds. In the State *4* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Wellfords Wharf *Aug 27*, 191*5*.

20-UNDERTAKER

ADDRESS

Good Block *1003 N. Hollis*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *716 Vincent*)

2-FULL NAME

(Residence in Baltimore: No. *716 Vincent*)

REGISTERED NO. C

ST.: *16* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: _____ yrs. _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

AUG 27 1915

ROBERT . KRAUTER,

Filed

191. BURIAL PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 21st* 191*5*, to *Aug 25* 191*5*, that I saw her alive on *Aug 24* 191*5*, and that death occurred, on the date stated above, at *1:30 P. m.*

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Geo. C. Shannon

M. D.

Aug 26, 191*5* (Address) *700 Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*McAuburn**Aug 27 1915*

20-UNDERTAKER

ADDRESS

James H. Dineen 1303 Packer

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1424ⁿ Mount* ST.; *15* WARD)

REGISTERED NO. C

2-FULL NAME *Robert Curtis*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1424 N. Mount*St.; *15* yrs., — mon. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

April

(Month)

1

(Day)

1871

(Year)

7-AGE,

*44**4**24*

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Had. Carrier

9-BIRTHPLACE, (State or Country),

Richmond Va.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Maria Bates

13-BIRTHPLACE OF MOTHER (State or Country),

Richmond Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rosa Curtis*(Address) *1424 N. Mount St.*

15-

Filed

AUG 27 1915

ROBERT KRAUTER

Burial Permits

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

August 25, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *August 24, 1915*, to *August 25, 1915* that I saw him alive on *August 24, 1915*, and that death occurred, on the date stated above, at *2 a. m.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

Arterio Sclerosis *Arterio Aneurysm* *Indefinite*(Signed) *Charles E. Clark* M. D.*Aug. 25, 1915* (Address) *1310 N. Gilman St*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Mt Auburn Cntry**Aug. 27, 1915*

20-UNDERTAKER

ADDRESS

*Alfred J. Ireland**1145 Schoder*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Church Home & Ref. ST.*)

2-FULL NAME

(Residence in Baltimore: No. *1623 E Baltimore*

REGISTERED NO. C

WARD) *40*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *25* yrs., *25* mos. *25* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, -
MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

Aug —, *1858*
(Month) (Day) (Year)

7-AGE,

57 yrs. — mos. — da.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

*Housewife*9-BIRTHPLACE,
(State or Country),*Russia*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Russia*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Lewis*(Address) *1419 E. Balto St*

15-

AUG 27 1915

ROBERT . KRAUTER

Filed

MORTAL PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug *26*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 4 1915, to *Aug 26* 1915,that I saw her alive on *Aug 26* 1915and that death occurred, on the date stated above, at *7:48* p.m.

The CAUSE OF DEATH* was as follows:

Post-operative Hemorrhage

Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Carcinoma of bile ducts*(Signed) *Dr. Ramonell Star**Aug 26* 1915 (Address) *Church Home & Ref.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *22* ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? *At home*Former or usual residence *1623 E. Baltimore St*

19-PLACE OF BURIAL OR REMOVAL,

St. Henry Belair Rd

DATE OF BURIAL,

8/27 1915

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Balto St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1366 N. Calhoun street, ST. 15 WARD)

FULL NAME

Any G. Pratt,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1366 N. Calhoun street,

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female,

4-COLOR OR RACE,

Colored,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single,

6-DATE OF BIRTH,

August 1st, 1915.

7-AGE,

0 yrs., 0 mos., 25 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

None,

9-BIRTHPLACE, (State or Country).

Baltimore, Md.

10-NAME OF FATHER,

Unknown,

11-BIRTHPLACE OF FATHER (State or Country).

Unknown,

12-MAIDEN NAME OF MOTHER

Annie Pratt,

13-BIRTHPLACE OF MOTHER (State or Country).

Virginia,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma V. Hall, friend,

(Address) 1366 N. Calhoun street.

15 AUG 27 1915

Filed

ROBERT K. KRAUTER
Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 25th, 1915.

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.

thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity et congenital asthenia cum artificial feeding.

CONTRIBUTORY (Secondary)

(Signed)

(Duration) 7 yrs., 11 mos., 25 ds.

Aug. 26 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

COLLEGE OF P. & S.

DATE OF BURIAL,

ADDRESS

20-UNDERTAKER, Commissioner of Health,

FOR ANATOMICAL PURPOSES.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2435 E. Hoffman ST.;WARD) 8

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathaniel E. Bennett(Residence in Baltimore: No. 2435 E. HoffmanSt.; 65 yrs., — mos., — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

July 21, 1850
(Month) (Day) (Year)

7-AGE,

65 yrs., — mos., — da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, at Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),Balto City

10-NAME OF FATHER,

Charles D. Bennett11-BIRTHPLACE OF FATHER,
(State or Country),Balto City

12-MAIDEN NAME OF MOTHER

Elizabeth Warren13-BIRTHPLACE OF MOTHER,
(State or Country),Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M. Bennett(Address) 2435 E. Hoffman

15-

AUG 27 1915

ROBERT . KRAUTER

Filed..... 191

Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 25, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 1 1915, to Aug 25 1915,that I saw him alive on Aug 23 1915,and that death occurred, on the date stated above, at 2:15 p.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart.(Duration) 1 yrs., — mos., — da.CONTRIBUTORY
(Secondary)(Duration) 1 yrs., — mos., — da.(Signed) H. J. Gentry M. D.Aug. 25, 1915. (Address) 622 W. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — da. In the State — yrs., — mos., — da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Int. Crem.

DATE OF BURIAL,

Aug 28, 1915

20-UNDERTAKER

William Oak

ADDRESS

502 E. North

087772 HEALTH DEPARTMENT--CITY OF BALTIMORE
 105087772
 CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. 2524 St. Fayette) St. 20 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)
 2-FULL NAME William Schropfer Gorseuch
 (Residence in Baltimore: No. 2524 St. Fayette St. 80 yrs. 6 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)

6-DATE OF BIRTH Feb 13, 1835
 (Month) (Day) (Year)

7-AGE 80 yrs. 6 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Builder
 (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto Md.

10-NAME OF FATHER John G. Gorseuch

11-BIRTHPLACE OF FATHER (State or country) Balto Co. Md.

12-MAIDEN NAME OF MOTHER Sarah E. Douglass

13-BIRTHPLACE OF MOTHER (State or country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Louise A. Gorseuch
 (Address) 2524 St. Fayette St.

15-AUG 27 1915 ROBERT J. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug 26, 1915
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 24, 1915, to, Aug 26, 1915, that I saw him alive on Aug 26, 1915, and that death occurred, on the date stated above, at 5:45 A m.
 The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 3 yrs. mos. ds.

Contributory (SECONDARY) Acute Enteritis

(Duration) yrs. mos. 2 ds.

(Signed), Thos. A. Schaefer M. D.
Aug 26, 1915 (Address) 2505 W. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park C. DATE OF BURIAL Aug 29, 1915

20-UNDERTAKER William Cook ADDRESS 502 E. North Ave

state CAUSE OF DEATH in plain terms, so that it may be properly entered is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 E Preston ST.; 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M Winter(Residence in Baltimore: No. 2008 E Preston St.; 60 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widow (Write the word.)6-DATE OF BIRTH, Nov 4, 1834 (Month) (Day) (Year)7-AGE, 80 yrs., 10 mos., — ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, Don't know11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER, Don't know13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Harwood(Address) 2008 E Preston15-AUG 27 1915
Filed..... 191.....
ROBERT KRAUTER,
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 25, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 15th 1915, to Aug 25th 1915, that I saw her alive on Aug 25th 1915, and that death occurred, on the date stated above, at 10:30 m. The CAUSE OF DEATH* was as follows:
Arteriosclerosis & pneumonia
& valvular heart disease
(Duration) 1 yrs., 4 mos., 10 ds.
CONTRIBUTORY Diabetes of 5 years (Secondary)
(Duration) 1 yrs., 1 mos., 1 ds.
(Signed) Wm. H. Singmaster M.D.
8/25/1915 (Address) 1502 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, Aug 28, 191520-UNDERTAKER, Wendell D. Apple ADDRESS, 378 N.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *225 N. Holl*)

2-FULL NAME *Margaret M. Hooke*

(Residence in Baltimore: No. *225 N. Holl*)

REGISTERED No. C

ST.: *6* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., *2* mos. *26* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Infant* (Write the word.)

6-DATE OF BIRTH, *May 31*, 1915 (Month) (Day) (Year)

7-AGE, *0* yrs., *2* mos., *26* da. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Infant* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balto Ind*

10-NAME OF FATHER, *Frank J. Hooke*

11-BIRTHPLACE OF FATHER (State or Country), *Ind*

12-MAIDEN NAME OF MOTHER, *Alice A. Stokes*

13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank J. Hooke*

(Address) *225 N. Holl St*

15- *ROBERT J. BRAUTER,*

AUG 27 1915 Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 26*, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes

(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... da.

(Signed) *Edgar P. Riddle* M. D. (Coroner.)

Aug 27, 1915 (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death ... yrs. ... mos. ... da. State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer* DATE OF BURIAL, *Aug 27 1915*

20-UNDERTAKER, *Murdell Lippel & Son* ADDRESS *37 S. Ann St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *1609 Lancaster*ST. *2*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Frank S. Kopinski(Residence in Baltimore: No. *1609 Lancaster*St.; yrs. mos. *8* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

Aug 19, 1915
(Month) (Day) (Year)

7-AGE,

yrs. mos. *8* ds.IF LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Baltimore Md*

PARENTS.

10-NAME OF FATHER,

*Thomas Skopinski*11-BIRTHPLACE OF FATHER
(State or Country),*Austria*

12-MAIDEN NAME OF MOTHER

*Anastasia Kanicka*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Thomas Skopinski

(Address)

1609 Lancaster St

15-AUG 27 1915

ROBERT

KRAUTER,

Filed....., 191...*Bureau of Health*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 27, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 26* 191*1*, to *Aug 27* 191*5*, that I saw him alive on *Aug 26* 191*5*, and that death occurred, on the date stated above, at *6:20* m. The CAUSE OF DEATH* was as follows:*Tetanus Nervosus*

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

J. J. Menton M. D.
Aug 27, 1915 (Address) *110 S. Brady*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Aug. 28, 1915

20-UNDERTAKER

M. F. Sadowski

ADDRESS

705 S. Ann

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 26 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day. hrs. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

FILE

ROBERT J. KRAUTER,
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on August 25 1915, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic pelvic inflammatory disease

Contributory
(SECONDARY)

faecal fistula

(Signed)

August 25 1915

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... 27 ds. State ✓ yrs ✓ mos ✓ ds.

Where was disease contracted, if not at place of death?

Former or usual residence 611 S. Bond St

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary

20-UNDERTAKER

William Fialkowski

DATE OF BURIAL

Aug 28 1915

ADDRESS

1618 Eastern Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital 3*)ST.; *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1N.)

2-FULL NAME

Joseph Cimmino(Residence in Baltimore: No. *2235 High*)St.; *12* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Married*

6-DATE OF BIRTH.

1st known, *1847*
(Month) (Day) (Year)

7-AGE.

48 yrs. *1* mos. *1* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Corse dealer*9-BIRTHPLACE,
(State or Country).*Italy*

10-NAME OF FATHER.

*Joseph Cimmino*11-BIRTHPLACE OF FATHER
(State or Country).*Italy*

12-MAIDEN NAME OF MOTHER

*Carmela Piaro*13-BIRTHPLACE OF MOTHER
(State or Country).*Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph Cimmino

(Address)

2235 High St

15-

ROBERT KRAUTER,

AUG. 27, 1915, Permit Clerk,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 26, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 25*, 1915, to *Aug 26*, 1915, that I saw him alive on *Aug 26*, 1915, and that death occurred, on the date stated above, at *4:10 P.M.*

The CAUSE OF DEATH* was as follows:

*Myocardial Infarction
+ cerebral thrombosis*(Duration) yrs. *2* mos. *2* ds.CONTRIBUTORY
(Secondary)*Arteriosclerosis*(Duration) yrs. *1* mos. *1* ds.(Signed) *James H. Williams, M.D.**8-27-1915*, 1915. (Address) *2235 High St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* ds. In the State yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

2235 High St

19-PLACE OF BURIAL OR REMOVAL.

St. Vincent

DATE OF BURIAL.

Aug. 27, 1915.

20-UNDERTAKER

Wendell Lippel & Son

ADDRESS

330 S. Bond St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *235-E-25*)ST. *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Harry Wesley Swift*(Residence in Baltimore: No. *235-E-25*)St. *life* yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOW,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

*Mar**23rd**1864*

(Month)

(Day)

(Year)

7-AGE,

*51**5**2*

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Managerial
Wholesale Grocer

9-BIRTHPLACE, (State or Country),

Balto Md

10-NAME OF FATHER,

Harry H. Swift

11-BIRTHPLACE OF FATHER (State or Country)

Balto Md

12-MAIDEN NAME OF MOTHER

Maie Fuller

13-BIRTHPLACE OF MOTHER (State or Country)

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Carrie R. Swift

(Address)

235-E-25

15-

Filed

AUG 27 1915

191

ROBERT . KRAUTH

Municipal Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Aug 25**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 23* 1915, to *Aug 25* 1915, that I saw him alive on *Aug 25* 1915, and that death occurred, on the date stated above, at *10:30* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

High Blood pressure

(Duration)

yrs.

mos.

ds.

(Signed)

Wm. J. Watson

M. D.

Aug 26, 1915 (Address) *2128 St Paul*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*London Park**Aug 29*, 1915.

20-UNDERTAKER

ADDRESS

Rev. Weber & Son 2503 Edmonstone

C87779

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

C87779

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-AUG 28 1915

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

8/25, 1915, to, 8/27, 1915,

that I saw him alive on 8/26, 1915,

and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Ac Gastro-enteritis

(Duration) yrs. mos. 3 ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. 1 ds.

(Signed)

8/27, 1915 (Address) 1135 2nd St. N. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Peter's

Aug 28, 1915

20-UNDERTAKER

ADDRESS 306

Walter Brown

N. Mount St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

50

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 144 Chapin St. 2 yrs. 0 mos. 0 ds.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 27, 1911
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1915, to Aug 27 1915, that I saw him alive on Aug 27 1915, and that death occurred, on the date stated above, at 2:45 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus
 (Duration)..... yrs. 2 mo. da.

CONTRIBUTORY *Scientific Management*
(Secondary)
Scientific Management (Duration) yrs. *1 1/2* mos. ds.

(Signed)..... M. D.
Aug 27, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 43 ds. In the State 70 yrs. mos. ds.

Where was disease contracted, if not at place of death? *at home*

Former or usual residence 1st of 1st Avenue, N. W.

12-PLACE OF BURIAL OR REMOVAL, <i>Interred in Re. de...</i>	DATE OF BURIAL, <i>Aug 30 1915</i>
--	---------------------------------------

20-UNDERTAKER	NAME	ADDRESS
	George F. Ruth	1735 Harbor Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1242 Hargest Lane ST. 9 WARD) REGISTERED NO. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Francis H. Wams
(Residence in Baltimore: No. 1242 Hargest Lane St.; 23 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE, White 5-STATUS, Married
(Write the word.)
6-DATE OF BIRTH, about / know, 1.....
(Month) (Day) (Year)
7-AGE, 62 yrs., — mos., — ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Barber
(b) General nature of industry, business, or establishment in which employed (or employer), House

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, John H. Wams
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER, —
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Herman Wams
(Address), 1242 Hargest Lane

15-
Filed AUG 28 1915 191. Chas M. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 27, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 25 1915, to Aug 26 1915, that I saw him alive on Aug 26 1915, and that death occurred, on the date stated above, at 4:40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx
Operation (Duration) 2 yrs., — mos., — ds.

CONTRIBUTORY Exhaustion (Secondary)
(Duration) — yrs., — mos., 1 ds.

(Signed) John Evans M. D.
8127, 1915. (Address) 502 Franklin Ter.

*State the DISEASE CAUSING DEATH, or, in deaths from VICARIOUS CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, — yrs., — mos., — ds. In the State, — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Church DATE OF BURIAL, Aug 30, 1915

20-UNDERTAKER, George J. Ruth ADDRESS, 1735 Hayford Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

323 N. Mount St.;

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John Calvin Foard

(Residence in Baltimore: No.

323 N. Mount

St.; 74 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word.)

Single

6-DATE OF BIRTH

Sept 24th

1838

(Month)

(Day)

(Year)

7-AGE

74 yrs., 11 mos., 3 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

House

9-BIRTHPLACE,

(State or Country),

Harford Co. Md.

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER

(State or Country) Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country) Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas. H. C. Foard

(Address)

Beachwood Ave. Catonsville

15-

Filed

AUG 28 1915

C. H. McClair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 27, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 25, 1915, to Aug. 27, 1915,

that I saw him alive on Aug. 25, 1915,

and that death occurred, on the date stated above, at 12-30 P.m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration)

4 yrs., 11 mos., 3 ds.

CONTRIBUTORY

(Secondary)

(Duration)

4 yrs., 11 mos., 3 ds.

(Signed)

Jas. C. Linn, M. D.

Aug. 27, 1915. (Address) 645 Columbia Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

Aug. 29, 1915.

20-UNDERTAKER

H. J. McKee & Son

ADDRESS

Remond & Co.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *E. Biddle & Loney Lane* ST.; *8* WARD)

2-FULL NAME

Matthew F. Beller(Residence in Baltimore: No. *E. Biddle St & Loney Lane*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

October 4, 1914
(Month) (Day) (Year)

7-AGE.

10 yrs., 24 mos., 24 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Md

10-NAME OF FATHER.

John Beller

11-BIRTHPLACE OF FATHER (State or Country).

Austria

12-MAIDEN NAME OF MOTHER.

Anna Dorbert

13-BIRTHPLACE OF MOTHER (State or Country).

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Beller*(Address) *E. Biddle St & Loney Lane*

15-

AUG 28 1915
Filed*Chas M. Sinclair*
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

August 27, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 26* 1915, to *Aug 27* 1915, that I saw him alive on *Aug 27* 1915, and that death occurred, on the date stated above, at *12:20* m.

The CAUSE OF DEATH* was as follows:

Gastroenteritis(Duration) ... yrs. ... mos. ... ds. *10 ds.*

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds. *1 ds.*(Signed) *H. J. Powers* M. D.... 191... (Address) *2571 E. Preston*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Redeemer Cemetery Aug 29, 1915

20-UNDERTAKER

ADDRESS

Christian Miller 2334 Jefferson

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87784

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Belt Ave

St.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marg. Eliz. Stiner

(Residence in Baltimore: No. 1625 Belt Ave

St.; yrs. 3 mos. 5 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female.

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word)

Single

6-DATE OF BIRTH,

Mar.

22

1915

(Month)

(Day)

(Year)

7-AGE,

yrs. 3 mos. 5 da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION.

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

M. M.

9-BIRTHPLACE,
(State or Country),

Balto. Md.

10-NAME OF
FATHER,

George Stiner

11-BIRTHPLACE
OF FATHER
(State or Country),

Balto. Md.

12-MAIDEN NAME
OF MOTHER

Bertha Goussier

13-BIRTHPLACE
OF MOTHER
(State or Country),

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Stiner

(Address) 1625 Belt Ave

15-

AUG 28 1915

ROBERT I. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug.

27th

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 23rd

1915

to Aug 27th

1915

that I saw her alive on Aug 27th

1915

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Ileocolitis

(Duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) Philip B. Toubert M. D.

Aug. 27, 1915. (Address) 1432 William St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutional Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Spinnville Md.

DATE OF BURIAL,

8/29, 1915

20-UNDERTAKER

J. Frew McCall

ADDRESS

39 E. Fort St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Balto City Jail* ST. *10* WARD)

2-FULL NAME

(Residence in Baltimore: No. *House above car barn York Rd* St. yrs. mos. *4* ds.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Married
(Write the word.)

6-DATE OF BIRTH

January 8, 1880
(Month) (Day) (Year)

7-AGE

35 yrs. *8* mos. *19* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer
General

9-BIRTHPLACE, (State or Country),

Lauree md

10-NAME OF FATHER,

John Vogt

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Mary A. Benolun

13-BIRTHPLACE OF MOTHER (State or Country)

Balto co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wisse Vogt

(Address)

Gorans

15-

AUG 28 1915

ROBERT T. KRAUTER,

Serial Permt. Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August *27*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, in-

inquest and that said deceased came to *death* (death, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Delirium tremens

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Chronic alcoholism

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Thos. H. Kramlich* M. D. (Coroner.)

August 27, 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. *4* ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Germany*

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

Aug 29, 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E North

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., 6 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

AUG 28 1915

ROBERT . KRAUTER,

Filed.....

191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 15 1915, to August 26 1915, that I saw her alive on Aug. 26 1915, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration)..... yrs. mos. 2 hrs.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. 11 ds.

(Signed).....

M. O. Neill, M. D.

Aug. 27, 1915 (Address) 108 N. Baltimore Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral

Aug. 28 1915

20-UNDERTAKER

ADDRESS

Geo. Riquart

1001 S. Jena

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 May StST. 5

WARD)

REGISTERED NO. C 087787FULL NAME Clarence Carter

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1311 May StSt.; 16 yrs., 8 mos., 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

Colored5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) Single

6-DATE OF BIRTH,

Dec 25, 1878
(Month) (Day) (Year)

7-AGE,

16 yrs., 8 mos., 2 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer9-BIRTHPLACE,
(State or Country),Md Balt.

10-NAME OF FATHER,

James Carter11-BIRTHPLACE OF FATHER
(State or Country),Pa

12-MAIDEN NAME OF MOTHER

Danforth (Laura)13-BIRTHPLACE OF MOTHER
(State or Country),Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Carter(Address) 1311 May St

15-

AUG 28 1915 ROBERT . KRAUTER,
Filed. 191. Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 26, 1915.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 1, 1915, to Aug 26, 1915,that I saw him alive on Aug 26, 1915,and that death occurred, on the date stated above, at 1:50 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 8 yrs., 8 mos., 2 ds.CONTRIBUTORY
(Secondary)(Duration) 8 yrs., 8 mos., 2 ds.(Signed) Robert J. Green, M. D.Aug 27, 1915 (Address) 120 1/2 Airquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 16 yrs., 8 mos., 2 ds. In the State 16 yrs., 8 mos., 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel cemetery Aug 29, 1915.

20-UNDERTAKER

ADDRESS

46 East 1400 Maryland St

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 2655 Francis ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Vinci(Residence in Baltimore: No. 2655 Francis St.: Life yrs. 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH Dec 4 1915
(Month) (Day) (Year)7-AGE 3 yrs. 8 mos. 23 ds. or 1 day hrs.
If LESS than 1 day, hrs. min.?8-OCCUPATION:
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE (State or country) Baltimore MdPARENTS
10-NAME OF FATHER Peter Vinci
11-BIRTHPLACE OF FATHER (State or country) Italy
12-MAIDEN NAME OF MOTHER Concettina Brocato
13-BIRTHPLACE OF MOTHER (State or country) Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Vinci
(Address) 2655 Francis St15-AUG 28 1915. ROBERT KRAUTER
Filed 191 Burial Permit 3 D. M.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug 27 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY That I attended deceased from Aug 26 1915 to Aug 27 1915,
that I saw her alive on Aug 27 1915,
and that death occurred, on the date stated above, at 6:30 P. m.
The CAUSE OF DEATH* was as follows:DysphagiaContributory (SECONDARY) X yrs. X mos. 2 ds.
(Duration)(Signed) J. Edw. Talbot M. D.
Aug 27 1915 [Address] 1353 W. North Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 0 yrs. 0 mos. 0 ds. In the 0 yrs. 0 mos. 0 ds. State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cathedral Cemetery DATE OF BURIAL Aug 28 191520-UNDERTAKER Wm. R. Rouse ADDRESS 2301 Green

C87789

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87789

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1908 W. Franklin*)ST: *20* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Henry F. Jordan.*(Residence in Baltimore: No. *1908 W. Franklin*)St.: *79* yrs. *8* mos. *20* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Widower.*
(Write the word)

6-DATE OF BIRTH *April 24, 1836*
(Month) (Day) (Year)

7-AGE *79* yrs. *8* mos. *20* ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION *Carriage Painter*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore - Md.*

10-NAME OF FATHER *Henry F. Jordan.*

11-BIRTHPLACE OF FATHER (State or country) *England.*

12-MAIDEN NAME OF MOTHER *unknown.*

13-BIRTHPLACE OF MOTHER (State or country) *Ireland.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. J. R. Hobson*

(Address) *1908 W. Franklin St.*

15

1915 AUG 28 8 28 AM

Chas. M. Sinclair
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August 26, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *August 9th, 1915* to *August 26th, 1915*, that I saw him alive on *August 26th, 1915*, and that death occurred, on the date stated above, at *6:15* P.m. The CAUSE OF DEATH* was as follows:

Acute Catarrhal Dysentery.

(Duration) yrs. mos. *18* ds

Contributory (SECONDARY) *Unknown.*

(Duration) yrs. mos. ds.

(Signed) *Wm. Conrad Bode* M. D.
Aug 27, 1915 (Address) *1900 Maryland Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Catholic Pres Ch Aug 30, 1915

20-UNDERTAKER

ADDRESS

James R. Byrnes *514 Wilson St.*

THIS CAUSE OF DEATH IS IN PART PRINTED, SO THAT THIS IS THE PROPERTY OF THE CITY OF BALTIMORE. IT IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87790

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital

ST.

WARD)

2-FULL NAME

Mary Phillips

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

3 to 306 S. Washington St

St.

3 yrs.

- mos.

- ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

July

(Month)

17

(Day)

1898

(Year)

7-AGE

17

yrs.

1

mos.

10

ds.

or

min.?

If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Russia

PARENTS

10-NAME OF FATHER

Don't know

11-BIRTHPLACE OF FATHER

(State or country)

Don't know

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER

(State or country)

Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Phillips

(Address)

306 S. Washington St.

15-

Filed

AUG 28 1915

Chas M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August

27

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

August 27, 1915, to August 27, 1915,

that I saw her alive on August 27, 1915,

and that death occurred, on the date stated above, at 10:40 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Infarction

Acute Cardiac Dilatation

Acute Pulmonary Edema.

7 hours

(Duration)

Contributory
(SECONDARY)

Acute Endocarditis

(Duration)

yrs.

mos.

15

ds.

(Signed), Nathaniel H. Brush

M. D.

August 27, 1915. [Address] Johns Hopkins Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. 8, mos. 8, ds. 8, State 8, yrs. 8, mos. 8, ds. 8.

Where was disease contracted, If not at place of death? At home

Former or usual residence 306 S. Washington Street

19-PLACE OF BURIAL OR REMOVAL

St. Stanislaus

DATE OF BURIAL

Aug 29, 1915

20-UNDERTAKER

M. J. Sudowski

ADDRESS

705 S. Ann St

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *John Hopkins Hospital* St. *5* WARD)

FULL NAME

William Johnson

(If death occurred in a hospital or institution, give its NAME instead of street and number and (N out No. 18.)

(Residence in Baltimore: No. *3 Spring St.* St.; *45* yrs. *10* mos. *13* ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

Colored

S-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

DATE OF BIRTH

October

(Month)

15

(Day)

1869

(Year)

AGE

45

yrs.

10

mos.

13

ds.

or

min.?

If LESS than

1 day, hrs.

OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Stevenson*

BIRTHPLACE

(State or country)

Maryland Baltimore

NAME OF FATHER

*Joseph Johnson*BIRTHPLACE OF FATHER
(State or country)*Maryland*

MAIDEN NAME OF MOTHER

*Helen Boling*BIRTHPLACE OF MOTHER
(State or country)*Maryland*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *S. G. Hile*

(Address)

Johns Hopkins Hospital

18-

AUG 28 1915

Chas. A. Suclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

August

(Month)

27

(Day)

1915

(Year)

I HEREBY CERTIFY, That I attended deceased from

July 12, 191*5*, to, *Aug 27*, 191*5*,that I saw him alive on *Aug 27*, 191*5*,and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

*Aneurysm aortic arch*Contributory
(SECONDARY)*Acute myocardial infarction secondary to coronary artery disease*

(Duration)

yrs.

mos.

ds.

12 hrs

(Signed)

George R. Dunn

M. D.

*Aug 28*191*5*

[Address]

Johns Hopkins Hospital

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place

of death

yrs.

1

mos.

15

ds.

In the

State

MD

yrs.

10

mos.

13

ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

*3 Spring St.
8 Spring St.*

19-PLACE OF BURIAL OR REMOVAL

Cambridge Md

DATE OF BURIAL

Aug 28, 191*5*

20-UNDERTAKER

John W. Henderson

ADDRESS

31 N. Caroline

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *87792*)

2. FULL NAME

(Residence in Baltimore: No. *87792*)REGISTERED NO. C *40*ST. *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, DIVORCED

6. DATE OF BIRTH

7. AGE

If LESS than 1 day, ... hrs. or ... min.?

8. OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE, (State or Country),

10. NAME OF FATHER,

11. BIRTHPLACE OF FATHER (State or Country),

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country),

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

AUG 29 1915

ROBERT K. KRAUTH

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH,

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 28 1915, to Aug 28 1915,

that I saw her alive on Aug 28 1915,

and that death occurred, on the date stated above, at 10:50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(No Operation or Mesenteric Vein)
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Edward Smith M. D.

Aug 28 1915 (Address) ... Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Cumberland Md.

Former or usual residence Cumberland Md.

19. PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cumberland Md. Aug 29 1915

20. UNDERTAKER

ADDRESS

Harry W. Mansson 805 N. Calvert

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Moreling St. WARD 13)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

2-FULL NAME

Kenneth Morehouse(Residence in Baltimore: No. 3540 Poole St.: 0 yrs., 4 mos., 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,WIDOWED,OR SEVERED,

(Write the word.)

Single

6-DATE OF BIRTH,

April 28, 1915
(Month) (Day) (Year)

7-AGE,

4 yrs., 13 mos., 13 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Imm.9-BIRTHPLACE,
(State or Country),Baltimore

PARENTS.

10-NAME OF FATHER,

Harry Morehouse11-BIRTHPLACE OF FATHER
(State or Country),MD

12-MAIDEN NAME OF MOTHER

Emma Wilson13-BIRTHPLACE OF MOTHER
(State or Country),MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Harry Morehouse

(Address).....

3540 Poole St.

15-

AUG 29 1915

ROBERT

KRAUTH

Baltimore

Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug., 1915, 28, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 9 1915, to Aug 27 1915, that I saw him alive on Aug. 27 1915, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Enteritis (mild)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

Aug 28, 1915 (Address) 3101 Clifton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mechanicsville, Canoe Co. Aug 27, 1915.

20-UNDERTAKER

ADDRESS

Chenoweth Son Chestnut

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 E. North Ave.

ST.: 12 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances M. R. Miller

(Residence in Baltimore: No. 427 E. North Ave.

St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow (Write the word.)

6-DATE OF BIRTH. May 31, 1859 (Month) (Day) (Year)

7-AGE. 56 yrs. 2 mos. 26 da. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. House work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, Robert B. Carroll

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary E. Nolan

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie C. McConky

(Address) 427 E. North Ave.

15- AUG 29 1915 ROBERT KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 27, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1915, to Aug 27 1915, that I saw her alive on Aug 26 1915, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows: Carcinoma of Uterus and Rectum (Clinical Diagnosis) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Infarction (Duration) yrs. mos. ds.

(Signed) Edward J. Booth M. D. 8726, 1915 (Address) 413 N. Washington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Loudon Park Cemetery Aug. 29, 1915

20-UNDERTAKER ADDRESS

Chas. G. Black, 1201 W. Mulberry St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH,

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said
(Inquest, au-topsy or inquiry.) and that said deceased came to death
on the day stated above.

The CAUSE OF DEATH was as follows:

Shock due to fractured ribs, punctured
pleura and lungs, the result of accidentally
being struck and run over by an auto-
mobile.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Mose M. Surges M. D.

Aug 28, 1915 (Address) 1729 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

on Cutaw near Lexington St.

Former or usual residence 715 Reservoir St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, No.

535 N Suzanne Ave

REGISTERED NO. C.

WARD)

2-FULL NAME

Francis P Quinn

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

535 N Suzanne Ave

Life
yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widowed

6-DATE OF BIRTH.

Mar 17th, 1850

(Month)

(Day)

(Year)

7-AGE.

65 yrs. 5 mos. 9 ds.

If LESS than 1 day,

hrs., or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Self
Street Cleaning Department

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

James Quinn

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Francis Quinn

(Address)

535 N Suzanne Ave

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 26th, 1915

(Month)

26 (Day)

1915 (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 21, 1915, to Aug 26, 1915,

that I saw him alive on Aug 25, 1915,

and that death occurred, on the date stated above, at 3:40 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis &
Organic Heart Disease

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY

(Secondary)

Coronary

(Duration) yrs. 1 mos. ds.

(Signed) M. J. Sagh

8/27/15, 1915 (Address) 709 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Cross

Aug 30, 1915

20-UNDERTAKER

ADDRESS

John A Moran & Ann

11-

AUG 29 1915

S. KRAUTER, Registrar.

Filed

191

Burial Permit Clerk

Registrar.

C87797

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

C87797

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 701 N Collington an 7 ST. 7 WARD)

2-FULL NAME

Norval C. Wiest

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM apt No. 18.)

(Residence in Baltimore: No. 707 N Collington an St. yrs. mos. ds.)

707 N Collington an

St.

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Dec.

24

1814

(Month)

(Day)

(Year)

7-AGE

8

mos.

3

ds.

or

min.?

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

None

9-BIRTHPLACE

(State or country)

Balto. md

PARENTS

10-NAME OF FATHER

Joseph M. Wiest

11-BIRTHPLACE OF FATHER

Balto md.

12-MAIDEN NAME OF MOTHER

Mable Fetsch

13-BIRTHPLACE OF MOTHER

Balto. md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mable Wiest

(Address)

701 N. Collington an

15-

AUG 29 1915

ROBERT . KRAUTER

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 27, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 24, 1915

to, Aug 27, 1915

that I saw him alive on

Aug 26, 1915

and that death occurred, on the date stated above, at 2:29 p.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

Contributory (SECONDARY)

Exhaustion

(Signed)

C. Wiest

8/28/15

1915 [Address] 405 Park Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

Aug 29, 1915

20-UNDERTAKER

W. J. Schoeffel

ADDRESS

1805 M. M. Ave. N. W.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Med. Gen. Hosp. St. 11* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore) No. *Med. Gen. Hospital* St.; yrs. *12* mos. *17* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, *married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Aug 1, 1884
(Month) (Day) (Year)

7-AGE,

31 yrs. *27* mos. *27* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business, or establishment in which
employed (or employer).*Housework*9-BIRTHPLACE,
(State or Country),*R. St. Mary's Co., Md*10-NAME OF
FATHER,*Nelson R. Hales*11-BIRTHPLACE
OF FATHER
(State or Country),*Md.*12-MAIDEN NAME
OF MOTHER*Katie McGill*13-BIRTHPLACE
OF MOTHER
(State or Country),*Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Henning*(Address) *1510 William St.*

15-AUG 29 1915

ROBERT J. KRAUTH

Filed..... 191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 28th 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
May 11th 1915, to *Aug 28th 1915*,
that I saw her alive on *Aug 28th 1915*,
and that death occurred, on the date stated above, at *2:10 A.M.*

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dil.

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Chronic Parenchymatous Nephritis*
(Duration)..... yrs. mos. ds.(Signed) *Frank E. Shipley* M. D.*Aug. 28 1915*. (Address) *Med. Gen. Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or usual residence *Hollings Ferry, Balt. Co., Md.*

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

Aug. 29., 1915.

ADDRESS

1422 Light St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *1602 Rustman*)ST. *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Fannie Fields*(Residence in Baltimore: No. *1602 Rustman*)St. *15* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word)

6-DATE OF BIRTH *unknown*, 1874
(Month) (Day) (Year)

7-AGE *41* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *City Balt.*

10-NAME OF FATHER *John Gibson*

11-BIRTHPLACE OF FATHER (State or country) *md*

12-MAIDEN NAME OF MOTHER *unknown*

13-BIRTHPLACE OF MOTHER (State or country) *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Thomas Fields*
(Address) *1602 Rustman*

15- *AUG 29 1915* *SOLEY . KRAUTER,*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *8/27*, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *8/1*, 1915, to *8/27*, 1915, that I saw him alive on *8/26*, 1915, and that death occurred, on the date stated above, at *1 A* m. The CAUSE OF DEATH* was as follows:

Carcinoma of stomach & liver

(Operation) (Duration) yrs. mos. ds.

Contributory (SECONDARY) *Tuberculosis* (Duration) yrs. mos. ds.

(Signed) *B. B. Chetty* M. D. *8/27*, 1915 (Address) *2135 Rustman*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Larchy, Balto. Co *8/29*, 1915

20-UNDERTAKER *md* ADDRESS

James H. Dennis Rustman st

is very important. See instructions on back of certificate.

Inf of Henry C & Eliz Bellmire
HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Whit* 5 SINGLE, ☒ MARKED *Single* WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH *August 25, 1915*
7 AGE *2 1/2* yrs. *2* mos. *12* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at *4 A.* m.

The CAUSE OF DEATH* was as follows:

*Premature Birth, 7 1/2 months.
Poorly developed child.*

Contributory (SECONDARY)

(Signed)

8/27/1915

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

15 AUG 29 1915

ROBERT KRAUTER

REGISTRAR

REGISTRAR

is very important. See instructions on back of certificate.

C87801

HEALTH DEPARTMENT---CITY OF BALTIMORE

C87801

CERTIFICATE OF DEATH

104

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *4 So Robinson* ST. *1* WARD)2-FULL NAME *Arcene Pearl Hughes*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)

(Residence in Baltimore: No. *4 So Robinson* St.; *x* yrs. *8* mos. *13* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *white* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Single*6-DATE OF BIRTH *Dec* *15*, 19*14*
(Month) (Day) (Year)7-AGE *x* yrs. *7* mos. *13* ds. or min.?
If LESS than 1 day, hrs.8-OCCUPATION
(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer) *none*9-BIRTHPLACE (State or country) *14 So Robinson St*10-NAME OF FATHER *William T Hughes*11-BIRTHPLACE OF FATHER (State or country) *Westminster Md*12-MAIDEN NAME OF MOTHER *Nellie C. Smith*13-BIRTHPLACE OF MOTHER (State or country) *Balt Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William T Hughes*(Address) *14 So Robinson St*15-AUG 29 1915
Filed 191ROBERT J. KRAUTER,
Baptist Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *8* *28*, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *25 Aug*, 191*5*, to, *28 Aug*, 191*5*, that I saw her alive on *Aug 27*, 191*5*, and that death occurred, on the date stated above, at *304* m.
The CAUSE OF DEATH* was as follows:*Exhaustion*(Duration) *x* yrs. *x* mos. *1* ds.
Contributory (SECONDARY) *Cholera Infantum*
(Duration) *x* yrs. *x* mos. *7* ds.
(Signed) *Jas L. Pomeroy* M. D.
Aug 28, 191*5* [Address] *248 So Third*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Oak Lawn Cemetery *Aug 30*, 191*5*

20-UNDERTAKER ADDRESS

Albert C. Fisher *221 N Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1125 Carralton Ave* St.; *16* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1125 Carralton Ave* St.; *40* yrs., *4* mos., *5* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*Colored*5-STATUS,
MARRIED, *married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

June 15, 1864
(Month) (Day) (Year)

7-AGE,

*51 yrs., 2 mos., 15 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, business,
or establishment in which
employed (or employer).....*Cook*
*Private*9-BIRTHPLACE,
(State or Country),*Hartford Conn*

PARENTS.

10-NAME OF
FATHER,*Demetrius Harris*11-BIRTHPLACE
OF FATHER
(State or Country),*Prince George Md*12-MAIDEN NAME
OF MOTHER*Catherine Thompson*13-BIRTHPLACE
OF MOTHER
(State or Country),*Prince George Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr Ella 13 and*(Address) *525 Robert Street*

15-

Filed

*AUG 29 1915**ROBERT J. KRAUTH,*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 27, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
June 24th 1915, to *Aug 26 1915*,
that I saw her alive on *Aug 26 - 1915*,
and that death occurred, on the date stated above, at *1:30 A m.*

The CAUSE OF DEATH* was as follows:

Nephritis (Bright's Disease)
(Duration) *about 1* yrs. *4* mos. *1* ds.CONTRIBUTORY
(Secondary)*antagonism* (Duration) *1* yrs. *4* mos. *1* ds.
(Signed) *J. E. Campbell* M. D.
Aug 27, 1915. (Address) *1369 N Carey St**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Ashbury Cemetery Aug 29th 1915.

20-UNDERTAKER

ADDRESS

Chas G. Bailey 1421 Jefferson Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *119 N. Paca* ST. *4* WARD)

2-FULL NAME *Lillian M. Kehler*

(Residence in Baltimore: No. *119 N. Paca*)

REGISTERED NO. C *50*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. — mos. *5* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*

4-COLOR OR RACE, *White*

5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH, *October 9, 1906*

(Month)

(Day)

(Year)

7-AGE, *8* yrs. *10* mos. *19* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Penn.*

10-NAME OF FATHER, *Sherman J. Kehler*

11-BIRTHPLACE OF FATHER (State or Country), *Penn.*

12-MAIDEN NAME OF MOTHER *Lillian Bull*

13-BIRTHPLACE OF MOTHER (State or Country), *Indiana*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Ida M. Reed*

(Address) *119 N. Paca St.*

15-

AUG 29 1915

ROBERT J. KRAUTER

Filed

191

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 28, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, au-

topsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) *5 hr.*

yrs.

mos.

da.

CONTRIBUTORY (Secondary)

(Duration) *3*

yrs.

mos.

da.

(Signed) *J. B. Carroll*

(Coroner)

M. D.

Aug 28, 1915

(Address) *113 N. Carrollton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death... yrs. mos. ds.

State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

Landon Park Cemetery

DATE OF BURIAL,

Aug. 31, 1915

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 West Baltimore St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1105 W. Lanvale street, ST. 16 WARD)

FULL NAME James A. Rolph,

(Residence in Baltimore: No. 1105 W. Lanvale street,

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, Married, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, August 8th, 1846. (Month) (Day) (Year)

7-AGE, 69 yrs. 0 mos. 20 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: Commission Merchant. (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) retired 8 yrs.

9-BIRTHPLACE, (State or Country), Maryland,

10-NAME OF FATHER, Samuel Rolph,

11-BIRTHPLACE OF FATHER, (State or Country), Maryland,

12-MAIDEN NAME OF MOTHER, Sarah Farrow,

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles W. Rolph, son,

(Address) 1043 W. Lanvale street.

15- AUG 29 1915 ROBERT KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 28th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came (his death) on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably sclerosis of the coronary arteries.

(Duration) yrs. mos. ds.

CONTRIBUTORY Arterio-sclerosis, (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Hemper M. D. (Coroner.)

Aug. 28 1915. (Address) 3310 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Grand Ridge Ave. Aug 29, 1915

20-UNDERTAKER, ADDRESS

Joy B. Cook 1003 W. Baltimore St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME

(Residence in Baltimore: No.

St.: 70 yrs. 3 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widow

6-DATE OF BIRTH

May 27, 1845
(Month) (Day) (Year)

7-AGE

70 yrs. 3 mos. 1 ds. If LESS than
1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Baltimore Md.

10-NAME OF FATHER

Stephen Beaver

11-BIRTHPLACE OF FATHER
(State or country)

Frederick Md.

12-MAIDEN NAME OF MOTHER

Christina Laimhard

13-BIRTHPLACE OF MOTHER
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Estella DeHoff

(Address)

306 S. Monroe St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 28, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 1915, to, Aug 1915,

that I saw her alive on Aug 27, 1915,

and that death occurred, on the date stated above, at 1509 m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(Duration) 2 yrs. mos. ds.

Contributory
(SECONDARY)

Apoplexy

(Duration) yrs. mos. ds.

(Signed) J. Frederick Leitz M. D.

Aug 28, 1915 (Address) 2040 E. 11th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Lorraine Cemetery

DATE OF BURIAL

Aug. 31, 1915

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 W. Eastman St.

is very important. See instructions on back of certificate.

15.

AUG 29 1915

ROBERT J. KRAUTER,

Burial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.;

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. *9* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR SEVERED.
(Write the word.)*Single*

6-DATE OF BIRTH,

October 24, 1915
(Month) (Day) (Year)

7-AGE,

10 mos. 2 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None**Infant*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's Inf. Asylum*(Address) *1401 Division St.*

15-AUG 29 1915

ROBERT . KRAUTER

Filed..... 191.....

BUTLAL. PERMIT. ALOR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 26, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 15, 1915, to Aug 26, 1915,*that I saw her alive on *Aug 26, 1915,*and that death occurred, on the date stated above, at *2:00 P.* m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Pneumonia* Duration yrs. mos. ds.

(Signed)

J. P. Carroll M. D.
Aug. 27, 1915. (Address) *615 Columbia Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

St. Vincent's Inf. Asylum

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral *Aug 27, 1915*

20-UNDERTAKER

ADDRESS

Marion Baker *46 Lafayette Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Earl Clarke(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.; yrs. *4* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, *Single*

(Write the word.)

6-DATE OF BIRTH,

October 28, 1915
(Month) (Day) (Year)

7-AGE,

9 mos. 28 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's Inf. Asylum*(Address) *1401 Division St.*

15-

AUG 29 1915

ROBERT K. BRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 27, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1st* 1915, to *August 26* 1915, that I saw him alive on *August 26* 1915, and that death occurred, on the date stated above, at *4:00 a. m.*

The CAUSE OF DEATH* was as follows:

Malnutrition and Malassimilation(Duration) yrs. *2* mos. ds.CONTRIBUTORY *Impetigo contagiosa*
(Secondary)(Duration) yrs. *1* mos. ds.(Signed) *J. B. Boulton* M. D.*Aug 27, 1915* (Address) *65 Columbia Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *4* mos. ds. In the State yrs. *9* mos. *28* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *St. Vincent's Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Ave *August 28, 1915*

20-UNDERTAKER

ADDRESS

Marion Prater, Son *506 Lafayette St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asylum* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Valentine Anthony(Residence in Baltimore: No. *St. Vincent's Inf. Asylum*St.: yrs. *6* mos. *13* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

Single
~~MARRIED,~~
~~WIDOWED,~~
~~OR SEPARATED,~~
(Write the word.)

6-DATE OF BIRTH,

February 14, 1915
(Month) (Day) (Year)

7-AGE,

yrs. *6* mos. *13* ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE,
(State or Country),*Md. Balto.*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's Inf. Asylum*(Address) *1401 Division St.*

15-

ROBERT KRAUTER

Filed *AUG 29 1915* Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 27, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *August 24, 1915*, to *August 26, 1915*, that I saw him alive on *August 27, 1915*, and that death occurred, on the date stated above, at *6:30 a.m.*

The CAUSE OF DEATH* was as follows:

Gastro-enteritis(Duration) yrs. *3* mos. *3* ds.CONTRIBUTORY
(Secondary)(Duration) yrs. *3* mos. *3* ds.(Signed) *J. E. Poulton* M. D.*Aug 27, 1915* (Address) *615 Columbia Ave*
per John A. McNeill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *6* mos. *13* ds. In the State yrs. *6* mos. *13* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *St Vincent's Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Ave *Aug 29, 1915*

20-UNDERTAKER

ADDRESS

Martin Maheson *16 Lafayette Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.: *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Inf. Asylum* St.: yrs. *5* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write the word.*) *Single*

6-DATE OF BIRTH,

January 13th, 1915
(Month) (Day) (Year)

7-AGE,

yrs. *7* mos. *14* ds. If LESS than 1 day. hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's Asylum*(Address) *1401 Division St.*

15-

AUG 29 1915
ROBERT KRAUTH
Bureau of Health
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 27th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1st, 1915, to *Aug 27th, 1915*,
that I saw her alive on *Aug 27th, 1915*,and that death occurred, on the date stated above, at *4⁰⁰ P. m.*

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY *Malnutrition*
(Secondary)

(Duration) yrs. 2 mos. ds.

(Signed) *J. E. Boulton* M. D.*Aug 28th, 1915* (Address) *615 Columbia Ave.*
per John A. Maxwell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *5* mos. ds. In the State yrs. *7* mos. *14* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *St. Vincent's Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*Catholic Church**Aug 29 1915*

20-UNDERTAKER

ADDRESS

Martin P. Kelly, 106 Lafayette Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87810

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 552 Oxford ST. 17 WARD)FULL NAME Lord M. E. Jester(Residence in Baltimore: No. 354 Oxford St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, Black 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)6-DATE OF BIRTH, April, 1915 (Month) (Day) (Year)7-AGE, 5 yrs. 5 mos. 5 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, none (b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), md10-NAME OF FATHER Garfield M. Jester11-BIRTHPLACE OF FATHER (State or Country), Va12-MAIDEN NAME OF MOTHER Minnie W. Wadock13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Garfield M. Jester(Address) 552 Oxford St.15- Chas M. SinclairFiled AUG 30 1915 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 29, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 28 1915, to Aug 29 1915,that I saw him alive on Aug 28 1915,and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY..... (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 1915 (Address) 1019 N. Wood St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel CemeteryDATE OF BURIAL, Aug 30 191520-UNDERTAKER Samuel EarhartADDRESS 916 Penna ave

C87811

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

150

C87811

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1002 S Kenwood Ave 1

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 17.)

2-FULL NAME Patrick Joseph Brady

(Residence in Baltimore: No. 1002 S Kenwood Ave Sr. yrs. mos. 2 1/2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male
4-COLOR OR RACE White
5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single
6-DATE OF BIRTH Aug 27, 1915
7-AGE yrs. mos. 2 1/2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Baltimore

10-NAME OF FATHER

John Brady

11-BIRTHPLACE OF FATHER (State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Mamie O'Hara

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Brady

(Address) 1002 S Kenwood Ave

15

Filed

AUG 30 1915

Chas M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 29, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1915, to Aug 29, 1915, that I saw him alive on Aug 28, 1915, and that death occurred, on the date stated above, at 9:00 a.m. The CAUSE OF DEATH* was as follows:

Heart disease

Patulent Pericardial
(Duration) yrs. mos. 2 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) L. H. Mohr M. D.
Aug 29, 1915 (Address) 2935 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt. Carmel

DATE OF BURIAL

Aug 31, 1915

20-UNDERTAKER

Hendell Lippel & Son 330 S. Bond St.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

Balti. Eye. Ear. & Throat Hosp. 3

WARD)

2-FULL NAME

Lucian Holmes Walker

(If death occurred in a hospital or institution, give its NAME instead of street and number and Ill. out No. 13.)

(Residence in Baltimore: No.

Cummings Mills

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6. DATE OF BIRTH

August 27, 1859

7. AGE

56 yrs. 1 mos. 21 ds. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Wholesale lumber.

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or country)Wilmington
North Carolina

10. NAME OF FATHER

John Wesley Walker

11. BIRTHPLACE OF FATHER
(State or country)Wicksboro.
N. C.

12. MAIDEN NAME OF MOTHER

Eliza James Gitt

13. BIRTHPLACE OF MOTHER
(State or country)Wilmington
N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Wesley Walker

(Address)

Cummings Mills Md.

15.

AUG 30 1915

Filed

Chas. M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 27, 1915

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 12, 1915, to Aug. 27, 1915,

that I saw him alive on Aug. 27, 1915,

and that death occurred, on the date stated above, at 9:00 p. m.

The CAUSE OF DEATH* was as follows:

Embolism of coronary artery.
Pulmonary External genital
Asphyxiation.

Contributory (Duration) yrs. mos. ds.

Pneumonia (SECONDARY) (Duration) yrs. mos. 14 ds.

(Signed) Wm. Ellingwood M. D.

Aug. 27, 1915. (Address) 125 N. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 16 ds. In the State yrs. 7 mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence Avenue 19

19. PLACE OF BURIAL OR REMOVAL

Thomas Harrison Forest

DATE OF BURIAL

Aug. 30, 1915

20. UNDERTAKER

Henry W. Jenkins & Sons 1011 N. Charles St.

is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX <i>Male</i>	4-COLOR OR RACE <i>white</i>	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) <i>single</i>
----------------------	---------------------------------	---

6 DATE OF BIRTH: August 28, 1915
(Month) (Day) (Year)

7 AGE

IF LESS than
1 day, ³ hrs.
or min?

hrs. mos. ds.

8. OCCUPATION

(a) Trade, profession, or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) *Maryland*

10. NAME OF FATHER *Harry Goldberg*

11-BIRTHPLACE
OF FATHER
(State or country) *Maryland*

PAR 12 MAIDEN NAME OF MOTHER *Mary Kushner*

13. BIRTHPLACE
OF MOTHER
(State or country) *Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

AUG 30 1915

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH August 28, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 28, 1915, to, Aug 28, 1915

that I saw him alive on Aug 25th, 1915
and that death occurred, on the date stated above, at 5 p m.
The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) 1 hr. yrs. mos. ds

Contributory Asphyxia neonatorum.
(SECONDARY) oh

(Duration) 2 yrs. mos. ds.
(Signed) M. B. Levin M. D.
Aug 29, 1915 (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death..... yrs. mos. / ds. In the State..... yrs. mos. / ds.

Where was disease contracted.

11 not at place of death?

Former or
usual residence 211 N. Wolfe St. Balt. Md.

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
 CITY OF BALTIMORE: (No. *Mercy Hospital* ST.; *4* WARD)
 2-FULL NAME *George W. Fair*
 (Residence in Baltimore: No. *117 Fourth St. Brooklyn Md* yrs. *✓* mos. *✓* ds. *✓*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
 6-DATE OF BIRTH, *Dec* *30*, *1883*
 (Month) (Day) (Year)

7-AGE, *31* yrs. *7* mos. *29* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Engineer*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Md.*

PARENTS.
 10-NAME OF FATHER, *George W. Fair*
 11-BIRTHPLACE OF FATHER (State or Country), *Md*
 12-MAIDEN NAME OF MOTHER *Not Known*
 13-BIRTHPLACE OF MOTHER (State or Country), *Not Known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *Elizabeth W. Fair (Wife)*
 (Address) *117 Fourth St Brooklyn Md*

15- *Chas M. Sinclair*
 Filed *Aug 30* 1915 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 28*, *1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 21*, 1915, to *Aug 28*, 1915, that I saw him alive on *Aug 28*, 1915, and that death occurred, on the date stated above, at *7:00 P* m.

The CAUSE OF DEATH* was as follows:

Cerebral Endarteritis
(Endarteritis)
 (Duration) *Don't know* ds.

CONTRIBUTORY (Secondary)

(Duration) *7* yrs. *7* mos. *29* ds.
 (Signed) *Edward J. Smith* M. D.
Aug 28, 1915. (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *7* yrs. *7* mos. *29* ds. State *Brooklyn Md*

Where was disease contracted, if not at place of death? *Brooklyn Md*

Former or usual residence *Brooklyn Md*

19-PLACE OF BURIAL OR REMOVAL, *CEDAR HILL.* DATE OF BURIAL *AUG 31 1915*

20-UNDERTAKER *ARMSTRONG-DENNY CO.* ADDRESS *715 Light St*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 18277 Whitmore Ave. ST. 15 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 13.)

2-FULL NAME Baby Phubus

(Residence in Baltimore: No. 1827 Whitmore Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-MINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, 13 hrs.
yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

Aug 28, 1915, to Aug 29, 1915,
that I saw him alive on Aug 28, 1915,
and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(62nd)

Contributory
(SECONDARY)

(Signed),

Edw. J. Fulton M. D.
Aug 29, 1915, [Address] 1353 W. North Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

15-

Filed

191

REGISTRAR

Chas. M. Mueland
221 N. Broadway

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 Whitmore Ave. ST. 15 WARD)

2-FULL NAME

Baby Phoebe

(Residence in Baltimore: No. 1827 Whitmore Ave. St. 15 yrs. 11 mos. 11 days)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Aug

28

1915

7-AGE

If LESS than
1 day, 11 hrs.,
mos. 11 ds. or x min?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or country)

Balto

10-NAME OF FATHER

Erola Phoebe

11-BIRTHPLACE OF FATHER

(State or country)

Frederick Md

12-MAIDEN NAME OF MOTHER

Flora Virginia Bock

13-BIRTHPLACE OF MOTHER

(State or country)

Frederick Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. A. J. Thayer

(Address)

1827 Whitmore Ave.

15-

FILE

191

Chas M. Sinclair

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 28, 1915, to, Aug 29, 1915,

that I saw her alive on Aug 28, 1915,

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Immature Birth
(6 mos)

Contributory (SECONDARY)

(Signed)

E. A. J. Thayer M. D.
Aug 29, 1915. [Address] 1253 W. North

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Catholic Cemetery

Aug 30, 1915

20-UNDERTAKER

ADDRESS

Albert E. Toller

2211-3dway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1203 Wellwood ave* St. *13* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1203 Wellwood ave* St. *13* yrs. *1* mos. *1* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female White

4-COLOR OR RACE.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

Aug 29th 1916
(Month) (Day) (Year)

7-AGE.

If LESS than 1 day.

yrs. *1* mos. *1* da.

hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country).*Baeto*

PARENTS.

10-NAME OF FATHER.

*Harvey E. Werson*11-BIRTHPLACE OF FATHER
(State or Country).*Baeto County*

12-MAIDEN NAME OF MOTHER

*Emma Smith*13-BIRTHPLACE OF MOTHER
(State or Country).*Brunswick Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harvey E. Werson

(Address)

1203 Wellwood ave

15-

Filed

*AUG 30 1915**Charles M. Tucker*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 29th 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I saw h^e alive on 191

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH² was as follows:*Placenta previa*
Pericarditis
Induced
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

St. Ann's Steels
119 1915 (Address) *J. L. J. J. J.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSFERS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

St. Ann's Steels *Aug 30 1915*

20-UNDERTAKER

ADDRESS

Mr. H. Higdon *1001 W 37th St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 407 S. Dallas St. ST. 3 WARD) REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Louisa Simpson
(Residence in Baltimore: No. 407 S. Dallas St. St. 3 yrs. 1 mon. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <u>Female</u>	4-COLOR OR RACE, <u>Colored</u>	5-SINGLE, <u>Single</u> MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, <u>Decem.</u> <u>5</u> , <u>1865</u> (Month) (Day) (Year)		
7-AGE, <u>50</u> yrs. <u>5</u> mos. <u>5</u> ds.		8-IF LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <u>House work</u> (b) General nature of industry, business, or establishment in which employed (or employer), <u>At home</u>		
9-BIRTHPLACE, (State or Country), <u>Maryland</u>		
PARENTS.	10-NAME OF FATHER, <u>Charlie Matthew</u>	
	11-BIRTHPLACE OF FATHER (State or Country), <u>Maryland</u>	
	12-MAIDEN NAME OF MOTHER, <u>Louisa Simpson</u>	
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Maryland</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charlie Matthew
(Address) 407 S. Dallas St.

15-

Filed Aug 20 1915

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 28, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 24 1915, to Aug 27 1915,
that I saw her alive on Aug 26 1915,
and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(Duration) 8 yrs. 5 mos. 5 ds.
CONTRIBUTORY (Secondary) Rheumatism
(Duration) 1 yrs. 1 mos. 5 ds.
(Signed) A. H. Russell M. D.
829 1915 (Address) 2311 Highland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 50 yrs. 5 mos. 5 ds. In the State 50 yrs. 5 mos. 5 ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Paul's cemetery DATE OF BURIAL, Aug. 21, 1915.

20-UNDERTAKER, Wilton Davis ADDRESS, 1608 McEllderry St

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 Augusta Ave ST. 70 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME (Infant) Howard Schlicker

Residence in Baltimore: No. 17 Augusta Ave.

St.: - yrs. - mos. 3 hrs. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH.

August 27, 1915
(Month) (Day) (Year)

7-AGE.

- yrs. - mos. - da.

If LESS than 1 day.

5 hrs. or - min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE, (State or Country).

Maryland.

10-NAME OF FATHER.

Not known

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER.

Hilda Schwalen Schlicker

13-BIRTHPLACE OF MOTHER (State or Country).

Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. K. Schlicker

(Address) 4107 Liberty Heights Ave

15-

AUG 30 1915 Cha. M. Sudair

Filed

101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 27, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 27, 1915, to August 27, 1915, that I saw him alive on August 27, 1915, and that death occurred, on the date stated above, at 9.30 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) - yrs. - mos. - da.

CONTRIBUTORY (Secondary)

(Duration) - yrs. - mos. - da.

(Signed) W. K. Schlicker M. D.

1915 (Address) 4107 Liberty Heights Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Ludon Park Cemetery Aug 30, 1915

20-UNDERTAKER

ADDRESS

J. B. Huppert 7238 Fredk Ave

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *532 N. Payson*)FULL NAME *Mary Elizabeth Heywood*(Residence in Baltimore: No. *532 N. Payson*)

REGISTERED NO. C

ST.: *20* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *18* yrs. *1* mos. *25* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) *Widow*6-DATE OF BIRTH *July 7*, 1863

(Month)

(Day)

(Year)

7-AGE *52* yrs. *1* mos. *21* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION *None*(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE (State or country) *Mo.*10-NAME OF FATHER *William Taylor*

PARENTS

11-BIRTHPLACE OF FATHER (State or country) *Mo.*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or country) *Mo.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ms. Emma Gardner*(Address) *1009 W. Baltimore St.*

AUG 30 1915

Filed

191

Chas. W. Sinclair
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August 28*, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *July 28*, 1915, to *August 28*, 1915.that I saw her alive on *August 27*, 1915, and that death occurred, on the date stated above, at *6:29* pm.

The CAUSE OF DEATH* was as follows:

Acute nephritis(Duration) yrs. *1* mos. *6* ds.Contributory (SECONDARY) *Exhaustion*(Duration) yrs. *6* mos. *6* ds.(Signed) *Bernie D. Williams*

M. D.

Aug 28, 1915 (Address) *532 N. Payson*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. *6* mos. *6* ds. State yrs. *6* mos. *6* ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL *Green Park*DATE OF BURIAL *Aug. 30*, 191520-UNDERTAKER *John B. Cook*ADDRESS *1003 W. Baltimore St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore No.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....

AUG 30 1915

16-

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....
(Inquest, au-

topsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock due to comp. fracture of left tibia and subluxation of L femur in result of accidentally being caught in gasoline engine. (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

(Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the form birth.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

On a farm near Waterbury, Md.

Former or usual residence.....Waterbury, Md.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *647 W. Lexington* ST.; *4* WARD)2-FULL NAME *Serge William Moore*(Residence in Baltimore: No. *647 W. Lexington* St.; *1* yrs., *5* mos., *5* dn.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Aug. 23, 1915*

(Month)

(Day)

(Year)

7-AGE, *1* yrs., *5* mos., *5* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.

10-NAME OF FATHER, *Daniel Moore*11-BIRTHPLACE OF FATHER (State or Country), *Balto. Co. Md.*12-MAIDEN NAME OF MOTHER, *Eda May Groves*13-BIRTHPLACE OF MOTHER (State or Country), *Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *W. C. M. Moore*(Address), *647 W. Lexington St.*

15-

Filed, *Aug 30 1915*

1915

Chas. M. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 28, 1915*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *Aug 27, 1915*, to *Aug 28, 1915*, that I saw him alive on *Aug 28, 1915*, and that death occurred, on the date stated above, at *11:50 a.m.*

The CAUSE OF DEATH* was as follows:

Cerebro-spinal Meningitis(Duration).....yrs.....mos.....ds. *7*

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *W. C. M. Moore* M. D.*Aug. 28, 1915* (Address) *323 Eastern Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Brooklyn Ave*DATE OF BURIAL, *Aug 30, 1915*20-UNDERTAKER, *Joseph Cook*ADDRESS, *603 N. Baltimore St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
 CITY OF BALTIMORE: (No. 513 N. Chapel ST.; 6 WARD) REGISTERED NO. C
 2-FULL NAME Frank Krivda
 (Residence in Baltimore: No. 513 N. Chapel St.; 22 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, (Write the word.) Married
 6-DATE OF BIRTH, Not known 1.....
 (Month) (Day) (Year)
 7-AGE, 51 yrs., mos., ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work..... Sailor
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Austria

10-NAME OF FATHER, Frank Krivda

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Veronica Brank

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maria Krivda

(Address) 513 N. Chapel St.

15- AUG 30 1915

Filed Aug 30 1915 Chas. M. Mearns

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 29, 1915.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 27 1915, to Aug 29 1915, that I saw him alive on Aug 28 1915, and that death occurred, on the date stated above, at 12-54 am.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)..... yrs. mos. 2 ds.

CONTRIBUTORY Cordic Dilatation
 (Secondary)

(Duration)..... yrs. mos. 1 ds.

(Signed) Wm. J. Mearns M. D.
Aug 30, 1915 (Address) 2008 N. Howard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, Sept 1, 1915.

20-UNDERTAKER Frank Crocker ADDRESS 194 N. Holliday

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *649 W. Fayette St* ST. *4* WARD)2-FULL NAME *Chas B Jasinski*(Residence in Baltimore: No. *649 W Fayette* St.; yrs. mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*Single*

6-DATE OF BIRTH

July 27
(Month)*1913*
(Day) (Year)

7-AGE

2 yrs. *1* mos. *2* ds. or min.?If LESS than
1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE
(State or country)*Beth City*

PARENTS

10-NAME OF FATHER

*Chas Jasinski*11-BIRTHPLACE OF FATHER
(State or country)*Lithuania*

12-MAIDEN NAME OF MOTHER

*Annie Bezzuti*13-BIRTHPLACE OF MOTHER
(State or country)*Lithuania*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Jasinski

(Address)

649 W. Fayette St.

15-

Filed

*Aug 30 1915**Chas M. Sinclair*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

*Aug 29*th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 28, 1915, to, *Aug 29*, 1915,that I saw him alive on *Aug 28*, 1915,and that death occurred, on the date stated above, at *9 a* m.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia(Duration) yrs. mos. ds. *7*Contributory
(SECONDARY)(Duration) yrs. mos. ds. *4*

(Signed)

Chas B. Sinclair M. D.
Aug 29, 1915 [Address] *1302 Broadway*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cem**Aug 31*, 1915

20-UNDERTAKER

ADDRESS

John Grieblich 500 S. Paca St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 5 yrs., — mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE, married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

not known, 1869
(Month) (Day) (Year)

7-AGE,

46 yrs., — mos., — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Housekeeper

9-BIRTHPLACE,
(State or Country),

Russia

10-NAME OF FATHER,

not known

11-BIRTHPLACE OF FATHER
(State or Country),

not known

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER
(State or Country),

not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony W. Winters

(Address) 22 Cedar St. Bay

15-

AUG 30 1915

Chas M. Hudson

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

aug 29, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
aug 24 1915, to aug 29 1915,
that I saw her alive on aug 29 1915,
and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

cancer of stomach
and pancreas
Chronic Gastritis
(Duration) 8 yrs., 8 mos., — ds.CONTRIBUTORY
(Secondary)(Duration) 8 yrs., 8 mos., — ds.
(Signed) Geo. H. Snarr M. D.
aug 29, 1915 (Address) Franklin Sq. 3805

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 5 mos. 0 ds. In the 16 yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Curtis Bay

19-PLACE OF BURIAL OR REMOVAL,

Holy Cross Cem

DATE OF BURIAL,

Aug. 31, 1915

20-UNDERTAKER

John Greblianka

ADDRESS

500 S. Pegg

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Room 701 & Bldg*)

St.:

WARD

REGISTERED No. C

2-FULL NAME *Nicholas Johnson*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *2000 Fleet*)

St.: yrs., *30* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Not known*

6-DATE OF BIRTH, *Not known*, 1 (Month) (Day) (Year)

7-AGE, *50* yrs. mos. ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Watchman* (b) General nature of industry, business, or establishment in which employed (or employer). *Merchants' Warehouse Co.*

9-BIRTHPLACE, (State or Country), *Greece*

10-NAME OF FATHER, *Not known*

11-BIRTHPLACE OF FATHER (State or Country), *Not known*

12-MAIDEN NAME OF MOTHER, *Not known*

13-BIRTHPLACE OF MOTHER (State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. P. Lucas*

(Address) *1622 Fleet St*

15-

Filed

UG 30 1915

191

Chas. M. Sinclair

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 28*, 191*5*. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental drowning

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Wm. A. Jones* M. D. (Coroner.)

Aug 29, 191*5*. (Address) *3116 O'Donnell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Woodlawn Cemetery* DATE OF BURIAL, *Aug. 30*, 191*5*

20-UNDERTAKER, *H. Sander & Sons* ADDRESS, *1710 Fleet St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *672 Caroline* ST.; *5* WARD) REGISTERED NO. C
2-FULL NAME *Betty Harris* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *672 Caroline St. N.* St.; *life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *female* 4-COLOR OR RACE *colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widow*
6-DATE OF BIRTH. *unknown*, 1 (Month) (Day) (Year)
7-AGE, *45* yrs. mos. ds. 12-LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Cook.*
(b) General nature of industry, business, or establishment in which employed (or employer). *Private*

9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.
10-NAME OF FATHER, *unknown*
11-BIRTHPLACE OF FATHER (State or Country), *unknown*
12-MAIDEN NAME OF MOTHER, *unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. Green*
(Address) *742 N. Spring St.*

15-FILED *Aug 30/1915* *Chas. M. Sinclair* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 29*, 191*5*.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *July*, 191*5*, to *Aug*, 191*5*, that I saw her alive on *Aug*, 191*5*, and that death occurred, on the date stated above, at *5:48 P.* The CAUSE OF DEATH* was as follows:

Ch. Hepatitis
(Duration) *6* yrs. mos. ds.

CONTRIBUTORY (Secondary) *dropy*

(Signed) *Wallis W. White* M. D.
Aug 30, 191... (Address) *1121 B. May*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Laurel Cemetery *Aug. 31*, 191*5*.

20-UNDERTAKER, ADDRESS

Chas. G. Bailey *Jefferson St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1500 Marshall* ST. *23* WARD)

REGISTERED NO. C.

FULL NAME

(Residence in Baltimore: No. *1500 Marshall* St. *45* yrs., *4* mos., *18* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *M*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Aug. 13*, 18*86*7-AGE, *69* yrs., *18* mos., *18* da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *Carpenter*
(b) General nature of industry, business, or establishment in which employed (or employer)...9-BIRTHPLACE, (State or Country), *Ireland*

PARENTS.

10-NAME OF FATHER, *Timothy Sughrue*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER, *Mary O'Connor*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Sughrue*(Address) *1500 Marshall*

15-

AUG 30 1915

191

Chas. M. Sinclair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 29*, 191*5*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 1* 191*5*, to *Aug 29* 191*5*, that I saw him alive on *Aug 29* 191*5*, and that death occurred, on the date stated above, at *6:00 P.M.*

The CAUSE OF DEATH* was as follows:

Coronary & Respiratory
Atherosclerosis(Duration) ... yrs. ... mos. ... da. *5*CONTRIBUTORY (Secondary) *Pulmonary Tuberculosis*(Duration) ... yrs. ... mos. ... da. *1*(Signed) *J. F. Sweetman* M. D.*Aug 28*, 191*5*. (Address) *1 E. Randall St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... da. In the ... State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *New Cathedral*DATE OF BURIAL, *Sept. 2*, 191*5*20-UNDERTAKER, *Geo. Wignall & Son*ADDRESS, *1000 E. Poca*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY

(Signed)

M. D.

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 143 Mosher ST. 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 143 Mosher St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH

February 13, 1863
(Month) (Day) (Year)

7-AGE.

52 yrs. 6 mos. 15 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired

Clerk B. & O. R. R.

9-BIRTHPLACE,
(State or Country).

Baltimore

10-NAME OF FATHER.

Mr. T. Rigney

11-BIRTHPLACE OF FATHER
(State or Country)

Frederick Md.

12-MAIDEN NAME OF MOTHER

Mary C. Cuyler

13-BIRTHPLACE OF MOTHER
(State or Country).

R. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. F. W. Whitman

(Address) 2526 Madison Ave.

15-

AUG 30 1915

Filed

191

C. M. Sullivan

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 29, 1915, to Aug. 29, 1915,

that I saw him alive on Aug. 29, 1915,

and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:

cerebral thrombosis

2 hours

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Howard M. B. B. M. D.

Aug. 29 1915. (Address) 1126 W. N. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Green Mount Cemetery

DATE OF BURIAL,

Aug. 31, 1915.

20-UNDERTAKER

Stewart & Howen Co 10820 North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2043 Bank ST.;

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert J. Collins(Residence in Baltimore: No. 2043 Bank St.;

yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Dec 3rd, 1867
(Month) (Day) (Year)

7-AGE,

48 yrs., 8 mos., 24 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Building Inspector

9-BIRTHPLACE, (State or Country),

Balto. Md.

10-NAME OF FATHER,

James W. Collins

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary A.

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lioba C. Collins(Address) 2043 Bank St.

15-

Filed 30 1915Chas M. Mueller
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 27, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Feb 4, 1914, to Aug 27, 1915.that I saw him alive on Aug 27, 1915,and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

ArteriosclerosisChronic NephritisCONTRIBUTORY (Secondary) Chronic Nephritis(Duration) 18 yrs., 10 mos., 10 ds.(Signed) Geo. Feller M. D.(Address) 1937 Gough St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death 18 yrs., 10 mos., 10 ds. In the State 18 yrs., 10 mos., 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

Aug. 31, 1915

20-UNDERTAKER

Lilly Zeiler

ADDRESS

403 S. Wofford

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH *Merry Hospital*
 CITY OF BALTIMORE (No. *175* ST. *3* WARD)
 *FULL NAME *Joseph W. Rappelt*
 (Residence in Baltimore: No. *414 S. Dallas* St.; yrs. *life* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
 (Write the word.)
 6-DATE OF BIRTH, *July* *5*, *1826*
 (Month) (Day) (Year)

7-AGE, *39* *99*
 yrs. mos. ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, *Driver*
 (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *City*

PARENTS.
 10-NAME OF FATHER, *John J. Rappelt*
 11-BIRTHPLACE OF FATHER (State or Country), *City*
 12-MAIDEN NAME OF MOTHER, *Mary N. Justice*
 13-BIRTHPLACE OF MOTHER (State or Country), *City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Coff*
 (Address) *104 S. Dallas St.*

15- Filed *Aug 30 1915* 191 *Chas. M. Sinclair*
 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *August* *27*, *1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*
 (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry*
 (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accident - Fracture skull due to fall from wagon.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Thos. H. Humberg* M. D.
 (Coroner.)

Aug. 28, 191*5*. (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Mt. Carmel Cem* DATE OF BURIAL, *Aug 31, 1915*

20-UNDERTAKER, *Lilly & Zile* ADDRESS *403 S. Wolfe*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Low ST.; 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francesco Lapaglia(Residence in Baltimore: No. 1120 Low St.; 1 yrs., 6 mos., 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)

6-DATE OF BIRTH, Feb 26, 1914
(Month) (Day) (Year)

7-AGE, 1 yrs., 6 mos., 3 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore city

10-NAME OF FATHER, Giustino Lapaglia
11-BIRTHPLACE OF FATHER (State or Country), Sicily
12-MAIDEN NAME OF MOTHER, Amella Bongioni
13-BIRTHPLACE OF MOTHER (State or Country), Sicily

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father(Address) 1120 Low St

15-AUG 30 1915 Chas M. Sudan
Filed, 1915 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 29 1915, to Aug 29 1915, that I saw him alive on Aug 29 1915, and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Convulsions
(Duration) 10 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) embolism
(Duration) yrs. mos. ds.

(Signed) Wm. J. Pettalio M. D.
Aug 30, 1915 (Address) 1038 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (Not Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincent's DATE OF BURIAL, Aug 30, 1915

20-UNDERTAKER, Jelly & Zile ADDRESS, 403 N. Wolfe

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2034 Frederick Ave ST. 20 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2034 Frederick Ave St. 73 yrs. 5 mos. 24 ds.)REGISTERED NO. C. 79 C87834

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Widowed

6-DATE OF BIRTH

13 March 1842

(Month) (Day) (Year)

7-AGE

73 yrs. 5 mos. 24 ds.If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Croer9-BIRTHPLACE
(State or country)Baltimore

10-NAME OF FATHER

Archibald Jamison11-BIRTHPLACE OF FATHER
(State or country)Ireland

12-MAIDEN NAME OF MOTHER

Sarah Dickey13-BIRTHPLACE OF MOTHER
(State or country)Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clarence B Jamison

(Address)

2034 Frederick Ave

15-

AUG 30 1915

Chas M Suclaw
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug. 28, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1915, to Aug. 28, 1915, that I saw him alive on Aug. 27, 1915, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Heart Disease
(Mitral Insufficiency)(Duration) 1 yr 4 mos. 4 ds.Contributory
(SECONDARY)(Duration) 1 yr 4 mos. 4 ds.(Signed) E. J. Dickey M. D.
Aug. 28, 1915 [Address] 1412 N. Monroe St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 73 yrs. 5 mos. 24 ds. In the 20 State MD yr 5 mos. 24 ds.Where was disease contracted?
If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

Aug 30, 1915

20-UNDERTAKER

George L. Schmat 1730 2101 Frederick Ave

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *136 N. West* ST. *23* WARD)2-FULL NAME *Ellen Allen*

(If death occurred in a hospital or institution, give its NAME instead of street and number and report No. 19.)

(Residence in Baltimore: No. *136 N. West* ST. *life* yrs. *life* mos. *life* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

FILED

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw *her* alive on *Aug 27* 1915,and that death occurred, on the date stated above, at *1030 P.* m.

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH **Hahnemann General Hospital,**
 CITY OF BALTIMORE (No. **1122 N. Mount street,** ST. **15** WARD)
 2-FULL NAME **Sarah Dodson,**
 (Residence in Baltimore: No. **1306 N. Stockton street,** St.; yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. **Female,** 4-COLOR OR RACE, **Colored,** 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, **Married,** (Write the word.)
 6-DATE OF BIRTH, **Unknown,** (Month) (Day) (Year)
 7-AGE, **38 ? yrs. ? mos. ? ds.** If LESS than 1 day,hrs. or....min.?
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work **Housewife,**
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Virginia,

10-NAME OF FATHER,

Charles Washington,

11-BIRTHPLACE OF FATHER (State or Country),

Virginia,

12-MAIDEN NAME OF MOTHER

Caroline Harden,

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Annie Breen, sister,**

(Address) **Unknown, Baltimore, Md.**

15-

AUG 30 1915

Filed

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Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, **August 27th, 1915.**
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an **inquiry** (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said **inquiry** (Inquest, autopsy or inquiry.) find that said deceased came to **her** death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental respiratory failure due to pressure of uterine fibroid against diaphragm during anaesthesia. ((tumor weighed 40 pounds))

CONTRIBUTORY **Operation for the removal of tumor** (Secondary) (Duration) yrs. mos. ds.

(Signed) **Fredrick M. D.** (Coroner.)

Aug. 28th, 1915. (Address) **3310 W. North ave.**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death **0 yrs. 0 mos. 1 ds.** In the State **0 yrs. 0 mos. 0 ds.**

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Auburn

Aug. 30 1915

20-UNDERTAKER

ADDRESS

James L. Davis

1303 Eastman

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1121 Briscoe St

ST. 21 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgeana Hayes

(Residence in Baltimore: No. 1121 Briscoe St

St. 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, Unknown, 1864. (Month) (Day) (Year)

7-AGE, 51 yrs. mos. ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housework (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Calvert Co Md

10-NAME OF FATHER, George Fisher

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co Md

12-MAIDEN NAME OF MOTHER, Mary Hebbbron

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles W Hayes

(Address) 1121 Briscoe St

15-

Filed 1911 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 27, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis Acute

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY Exhaustion (Secondary)

(Duration) yrs. mos. 3 ds.

(Signed) E. J. Scott, M. D. (Coroner.)

Aug 28, 1915 (Address) 517 Scott St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, DATE OF BURIAL, Aug 30, 1915.

20-UNDERTAKER, ADDRESS, 907 Hollister

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 Jefferson ST.; 6 WARD)

REGISTERED No. C

2-FULL NAME Catherine Waters

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2201 Jefferson St.; 66 yrs., 6 mos., 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow6-DATE OF BIRTH, Nov 19th 1848

(Month)

(Day)

(Year)

7-AGE, 66 yrs., 9 mos., 10 ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) At home9-BIRTHPLACE, (State or Country), City10-NAME OF FATHER, John Bepnick11-BIRTHPLACE OF FATHER (State or Country), Md12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Waters(Address) 2201 Jefferson St

15-

Filed 30 1915

191

Registrar. Chas McClair

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 29, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 26 1915, to Aug 29 1915, that I saw her alive on Aug 29 1915, and that death occurred, on the date stated above, at 3:50 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis..... (Duration) 2 yrs., 7 mos., 10 ds.

CONTRIBUTORY (Secondary)

..... (Duration) 7 yrs., 7 mos., 10 ds.(Signed) Glennett Robertson M. D.Aug 30, 1915 (Address) 2129 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs., 7 mos., 10 ds. In the State 7 yrs., 7 mos., 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt CarmelDATE OF BURIAL, Sept 1, 191520-UNDERTAKER Philip HerwigADDRESS 2016 Orleans St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 Orleans ST.; 6 WARD)

REGISTERED NO. C

2-FULL NAME Sophia Switzer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2223 Orleans St.; 65 yrs., 1 mos., 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow
(Write the word.)6-DATE OF BIRTH, July 26th, 1830

(Month)

(Day)

(Year)

7-AGE, 85 yrs., 1 mos., 2 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country), Germany10-NAME OF FATHER, Unknown11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant, Thos E. Lettig)(Address, 2223 Orleans St.)

15-

Filed Aug 30 1915

16-

Registrar. Chas M. Sudar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 28, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 12 1915, to Aug 28 1915, that I saw her alive on Aug 27 1915, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease(Duration) 1 yrs., 1 mos., 1 ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs., 1 mos., 1 ds.(Signed) George Robertson M. D.Aug 30, 1915 (Address) 2129 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs., 1 mos., 1 ds. In the State 1 yrs., 1 mos., 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL, Aug 31, 191520-UNDERTAKER Philip HerwigADDRESS 2016 Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 E. Federal St.

ST.;

WARD)

REGISTERED NO. C

2-FULL NAME Edward A. Redmond

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1515 E. Federal St.St.; Lifetime yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

August 16th. 1887, 1
(Month) (Day) (Year)

7-AGE,

33

yrs.

-

12

mos.

da.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

Chas. M. Redmond11-BIRTHPLACE OF FATHER
(State or Country),Maryland

12-MAIDEN NAME OF MOTHER

Ellis Callahan13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Chas M. Redmond.(Address) 1515 E. Federal St.

15-

Filed.....

191

Chas M. Redmond

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 28, 1916.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 1 1915 to Aug 28 1916,
that I saw him alive on Aug 28 1916,
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis..... (Duration) 4 yrs. 4 mos. 4 ds.
CONTRIBUTORY Acute Cardiac Disturbance
(Secondary)..... (Duration) 4 yrs. 4 mos. 4 ds.
(Signed) Chas M. Redmond M. D.
Aug 30, 1916. (Address) 418 E. Federal St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

8/30/16, 1916

20-UNDERTAKER

ADDRESS

Chas F. Evans & Son 115 W. Mt. Royal Ave

HEALTH DEPARTMENT--CITY OF BALTIMORE

PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

DATE OF BIRTH

unknown, 1
(Month) (Day) (Year)

AGE

73

yrs.

mos.

ds.

If LESS than
1 day, hrs.
or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Drugstore

BIRTHPLACE
(State or country)

Maryland.

10-NAME OF FATHER

unknown.

11-BIRTHPLACE OF FATHER
(State or country)

unknown

12-MAIDEN NAME OF MOTHER

Eliza Pitt.

13-BIRTHPLACE OF MOTHER
(State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Eliza Barrett.
(Address) Guilford & Lafayette Aves

15-

Filed

AUG 30 1915

ROBERT J. KRAUTER,
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 29, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

August 27, 1915, to, Aug 29, 1915.

that I saw him alive on Aug 24, 1915.

and that death occurred, on the date stated above, at 4:30 AM.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 6 yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Aug 30, 1915 (Address) 127 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cemetery

Aug 31, 1915

20-UNDERTAKER

ADDRESS

E A Wietfeld Jr.

2113 Greenmount

is very important. See instructions on back of certificate.

C87842

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (NO

FULL NAME

(Residence in Baltimore, No

WARD)

St. 20 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME, instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word) Single
6 DATE OF BIRTH Apr 30, 1888 (Month) (Day) (Year)		
7 AGE 27 yrs. 4 mos. ds. or min.?		
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None		
9 BIRTHPLACE (State or country) England		
PARENTS	10 NAME OF FATHER W. Howell Geare	
	11 BIRTHPLACE OF FATHER (State or country) England	
	12 MAIDEN NAME OF MOTHER Ann Scott	
	13 BIRTHPLACE OF MOTHER (State or country) India	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

AUG 30 1915

ROBERT

KRAUTH

Bureau Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

April 13th, 1915, to Aug. 30th, 1915,
that I saw her alive on Aug 30th, 1915,
and that death occurred, on the date stated above, at 11 a.m.
The CAUSE OF DEATH* was as follows:

Toxic Nephritis

Contributory
(SECONDARY)

(Signed)

Aug 30th, 1915

(Address) 1700 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cumberland

20-UNDERTAKER

W. J. Sickner

ADDRESS

704 N. Perry

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country).10-NAME OF
FATHER.11-BIRTHPLACE
OF FATHER
(State or Country).12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed.

AUG 30 1915

ROBERT KRAUTER

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(Operation Aug 23, 1915)
(Duration) Do not knowCONTRIBUTORY
(Secondary)(Signed) Edward P. Smith M. D.
Aug 29, 1915 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 5 E. Mulberry St

Former or usual residence 5 E. Mulberry St

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Peters Cemetery

Aug 31, 1915

20-UNDERTAKER

ADDRESS

Henry W. Means & Son

805 N. Calvert St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1517 N. Caroline

ST.;

8

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Philip H. Herrmann

(Residence in Baltimore: No.

1517 N. Caroline st

St.: 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

January 7th, 1880

(Month)

(Day)

(Year)

7-AGE,

35 yrs. 7 mos. 22 ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Stationery

9-BIRTHPLACE,
(State or Country),

San Francisco Cal.

10-NAME OF FATHER,

John Herrmann

11-BIRTHPLACE OF FATHER
(State or Country).

Pittsburg Pa

12-MAIDEN NAME OF MOTHER

Annie E Lamb

13-BIRTHPLACE OF MOTHER
(State or Country).

Annapolis Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Annie E Herrmann

(Address)

1517 N. Caroline st

15-

AUG 30 1915

ROBERT J. KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

August 29, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 13 1915, to Aug 29 1915,

that I saw him alive on Aug 29 1915,

and that death occurred, on the date stated above, at 11:20 a.m.

THE CAUSE OF DEATH* was as follows:

Heart failure Pneumonia Lobar

CONTRIBUTORY
(Secondary)

Tuberculosis 15 ds.

Tuberculosis 16 ds.

(Signed) R. J. Davis M. D.

Aug 29, 1915. (Address) 1513 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Loring Ridge Cemetery

DATE OF BURIAL,

Sept 1st, 1915.

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E Monument

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *1227 N. Lombard* ST. *18* WARD)

2-FULL NAME *Henry Brice Barnes*

(Residence in Baltimore: No. *1227 N. Lombard* St.; *3* mos.

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Unknown

7-AGE

About 71

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired Blacksmith

9-BIRTHPLACE (State or country)

Howard Co. Md.

PARENTS

10-NAME OF FATHER

James Barnes

11-BIRTHPLACE OF FATHER (State or country)

Not Known

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER (State or country)

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Chas. P. Spedden (Sister)
1227 N. Lombard St.

15-

FILE

AUG 30 1915

ROBERT KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 28, 1915

17- I HEREBY CERTIFY, That I attended deceased from

June 25, 1915 to Aug 28, 1915

that I saw him alive on *Aug 28, 1915*

and that death occurred, on the date stated above, at *8:45 P.M.*

The CAUSE OF DEATH* was as follows:

Senile Arterio-Sclerosis

Contributory (SECONDARY)

Enteritis - Colitis

(Signed)

Henry C. White

Aug 28, 1915

[Address] *1203 St. Fayette St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. in the State, yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt Olivet Cemetery

DATE OF BURIAL

Aug 31, 1915

20-UNDERTAKER

John F. Fields 1203 St. Fayette St.

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87846

CERTIFICATE OF DEATH.

79
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 553 Union

ST.; 13 WARD)

2-FULL NAME

Elizabeth Wilson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 553 Union

St.; 98 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH,

Sept. 2, 1873

7-AGE,

41

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Domestic at home

9-BIRTHPLACE, (State or Country),

Md.

10-NAME OF FATHER,

David Harris

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Harriet Williams

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

John S. Williams
807 George St.

15-

Filed

AUG 30 1915

ROBERT KRAUTER,

101 Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 28, 1915

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15 1914, to Aug. 28 1915, that I saw him alive on Aug. 27 1915, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Cardiac Disease

(Duration) 1 yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs., mos., ds.

(Signed) J. S. Schuchert M. D.

Aug. 28 1915 (Address) 2062 Dulaney Ave.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Lawn Cemetery

DATE OF BURIAL,

Aug. 30, 1915

20-UNDERTAKER

John H. Owens

ADDRESS

1222 Dulaney

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *104*)

FULL NAME

Rudine Safczynski

(Residence in Baltimore: No. *214 S. Ann*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life except from Aug 16, 1915
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Single

6-DATE OF BIRTH,

Sept.

1st

1914

(Month)

(Day)

(Year)

7-AGE,

11 mos. 28 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Frank Safczynski

11-BIRTHPLACE OF FATHER (State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Sophia Sefinski

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Safczynski*

(Address) *214 S. Ann St.*

15-

Filed *AUG 30 1915*

ROBERT KRAUT

Marital Record Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August

29

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Gas in Cerebrum

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *D. W. Jones* M. D. (Coroner.)

Aug 30, 1915 (Address) *5116 O'Donnell St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaw

DATE OF BURIAL,

Aug 31, 1915

20-UNDERTAKER

M. S. Sadowski

ADDRESS

705 N. Ann St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

1-PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.,

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signature)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

18-

AUG 30 1915

ROBERT J. KRAUTH
REGISTERARSt Charles Pikesville
H. C. Wiedefeld 914 Greenview

C87849

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 919 Argyle avenue,

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Travers,

(Residence in Baltimore: No. 919 Argyle avenue,

St.; yrs., mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female,

4-COLOR OR RACE,

Colored,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single,

6-DATE OF BIRTH,

August 9th, 1915.
(Month) (Day) (Year)

7-AGE,

0 yrs., 0 mos., 21 ds.

IF LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None,

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore, Md.

10-NAME OF
FATHER,

Harry Brooks,

11-BIRTHPLACE
OF FATHER
(State or Country),

Maryland,

12-MAIDEN NAME
OF MOTHER

Ethel Travers,

13-BIRTHPLACE
OF MOTHER
(State or Country),

Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel Travers, mother.

(Address) 919 Argyle avenue.

15-AUG 30 1915

ROBERT KRAUTER

Filed..... 191...
Municipal Health Officer
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 30th, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Congenital asthenia,
(Cause unknown.)

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)(Duration) yrs. mos. ds.
(Signed) Frederick Humpal, M. D.
(Coroner.)

Aug. 30th 1915 (Address) 3310 W. North av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mount Auburn Cem., Aug. 31, 1915.

20-UNDERTAKER

John A. Padden

DATE OF BURIAL,

ADDRESS

142 W. Hill St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87850

CERTIFICATE OF DEATH.

170 C87850

PLACE OF DEATH

CITY OF BALTIMORE (No. *Mary Hospital* ST. *8* WARD)

2-FULL NAME

Herman G. Schroeter(Residence in Baltimore: No. *2618 E. Oliver St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

*White*5-STATUS,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Married*

6-DATE OF BIRTH

December 10, 1881
(Month) (Day) (Year)

7-AGE,

63 yrs. *8* mos. *17* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Carpenter*

9-BIRTHPLACE,

(State or Country),

Pa.

10-NAME OF FATHER,

Emil Schroeter

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Harriet Kneuder

13-BIRTHPLACE OF MOTHER

(State or Country),

German Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annie Schroeter*(Address) *2618 E. Oliver St.*

15-

Filed

AUG 30 1915

191

ROBERT

KRAUTER

Baltimore Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 28, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)find that said deceased came to *death* (Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

*Chronic interstitial nephritis
Uremia**about 3* (Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Thos. Frank* M. D. (Coroner.)*Aug. 30, 1915* (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *about 4 yrs.* In the of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence *2618 E. Oliver St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Balto Cemetery Aug. 31, 1915

20-UNDERTAKER

ADDRESS

F. A. Krause 703 Hanover

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87851

C87851

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *607 Hanover*)

ST.: *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary M. Schreyer

(Residence in Baltimore: No. *607 Hanover*)

St.: *32* yrs., *2* mos., *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

married
(Write the word.)

6-DATE OF BIRTH

July 17, 1856
(Month) (Day) (Year)

7-AGE

59 yrs., *1* mos., *3* ds.

If LESS than 1 day.

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *no paid occupation*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

Richard Erdman

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Margaret Erdman

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John G. Schreyer, husband*

(Address) *607 Hanover st.*

15-

AUG 30 1915

ROBERT . KRAUTER,

Filed *Sept. 1st* *Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 30, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct.* 191*4*, to *Aug. 30* 191*5*, that I saw her alive on *Aug. 29* 191*5*, and that death occurred, on the date stated above, at *5 P. m.*

The CAUSE OF DEATH* was as follows:

Organic heart disease
(mitral regurgitation)

about (Duration) *3* yrs., *2* mos., *2* ds.

CONTRIBUTORY (Secondary)

(Duration) *3* yrs., *2* mos., *2* ds.

(Signed) *L. F. Shewell* M. D.

Aug. 30, 1915 (Address) *7221 Madison ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Center

Sept. 1st 1915

20-UNDERTAKER

ADDRESS

F. A. Krause

703 Hanover

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. 9 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word)

6-DATE OF BIRTH.

7-AGE.

IF LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

ROBERT J. KRAUTER
Burial Permit Officer
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 29. m.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

AUG 30 1915

ROBERT

KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from
that I saw him alive on
and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *406 Federal* ST.; *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *406 Federal* St.; *Life* yrs., *0* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Single*

6-DATE OF BIRTH.

Oct 9 - 1914
(Month) (Day) (Year)

7-AGE,

10 21
yrs. mos. ds.IF LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*Patrick Carberry*11-BIRTHPLACE OF FATHER
(State or Country),*Ireland*

12-MAIDEN NAME OF MOTHER

*Bridget Holden*13-BIRTHPLACE OF MOTHER
(State or Country),*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Patrick Carberry*(Address) *406 Federal St.*

15-

AUG 30 1915
Filed..... 191*ROBERT J. KRAUTH,*
DEPUTY REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug - 30th 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 18th 1915, to *Aug 30th 1915*,that I saw her alive on *Aug 30th 1915*,and that death occurred, on the date stated above, at *8 P. m.*

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia(Duration)..... yrs..... mos. *2* ds.CONTRIBUTORY
(Secondary)*Whooping Cough*(Duration)..... yrs..... mos. *12* ds.(Signed)..... *T. B. Frank* M. D.*Aug 30 1915* (Address) *1315 N. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Cross Cem Aug 31..... 1915

20-UNDERTAKER

ADDRESS

*H. C. Wiedefeld 914 Green Mt. Ave**1315 N. North Ave*

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

Str. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6-DATE OF BIRTH February 17, 1859 (Month) (Day) (Year)

7-AGE 56 yrs. 6 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, particular kind of work Carpenter Foreman (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore Md

10-NAME OF FATHER Carl Pletz

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Augusta Lehmer

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Mrs Annie Pletz (wife) (Informant)

(Address) 1012 Patapsco St

15-Filed AUG 31 1915 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH August 29, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from August 30, 1915, to August 29, 1915, that I saw him alive on August 28, 1915, and that death occurred, on the date stated above, at 3 a.m. The CAUSE OF DEATH* was as follows:

Organic disease of the heart & kidneys (Duration) yrs. mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) Chas. M. Reinhardt, M. D. Aug 30, 1915 (Address) 1017 Scharles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cedar Hill DATE OF BURIAL Sept 1, 1915

20-UNDERTAKER ADDRESS Edw. J. Fanning 1460 Battery an

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *1129 Low St.* ST.; *5* WARD) REGISTERED NO. C *29* *C87853*
2-FULL NAME *Andrew Goetz*
(Residence in Baltimore: No. *1129 Low St.* St.; *Life* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, *single*
6-DATE OF BIRTH *Mar 13th.*, 1885
7-AGE *30* yrs. *5* mos. *15* ds. IF LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Shoemaker*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country), *Ind.*

10-NAME OF FATHER *Frank Goetz*
11-BIRTHPLACE OF FATHER (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER *Catharine Down*
13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Cath. Goetz*
(Address) *1129 Low St.*

15-

Filed *1* 1915 *Chas M. Sinclair*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug - 28*, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 7*, 1915, to *Aug 28*, 1915, that I saw him alive on *Aug 26*, 1915, and that death occurred, on the date stated above, at *8:40* m.

The CAUSE OF DEATH* was as follows:

Phthisis Florida

CONTRIBUTORY (Secondary) *Emphysema*

(Signed) *Geo. Clinton Blades* M. D.
9/29/15, 1915 (Address) *143 N. B'way.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Oak Lawn* DATE OF BURIAL, *Aug 31*, 1915

20-UNDERTAKER *John A. Moran & Co.* ADDRESS *B'way*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH + 92

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *U.S. Marine Hospital* WARD)

2-FULL NAME *John R. Hayes*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *U.S. Marine Hospital* St. yrs. mos. dn.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *Colored* 5-SINGLE *Married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH (Month) (Day) (Year) *1*

7-AGE *28* yrs. mos. ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work *Seaman*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Va*

10-NAME OF FATHER *Unknown*

11-BIRTHPLACE OF FATHER (State or country) *Unknown*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or country) *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE *From Hospital record.*
(Informant)

(Address)

15- *Chas M. Lueder*
Filed *1* 1915 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *August 28, 1915.*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug. 27, 1915*, to *Aug. 28, 1915*, that I saw him alive on *Aug. 28, 1915*, and that death occurred, on the date stated above, at *1:45 P.M.*

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

Contributory (SECONDARY) *Multiple Abscess Liver*
Unknown (Duration) yrs. mos. ds.
(Signed) *M. Stewart* M. D.
Aug. 29, 1915. [Address] *U.S. Marine Hospital*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death. — yrs. — mos. *1 1/2* In the State. — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? *Unknown*

Former or usual residence *Philadelphia, Pa.*

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Laurel Cemetery *Aug. 31, 1915*

20-UNDERTAKER ADDRESS *John H. Toaderin* *142 Hill Street*

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 C87853

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.; *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Stanislaus Haupt(Residence in Baltimore: No. *St. Vincent's Infant Asylum.* St.; yrs. *1* mo. *16* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

*MARRIED**Single*

(Write the word.)

6-DATE OF BIRTH,

*May**7th**1915*

(Month)

(Day)

(Year)

7-AGE,

3 yrs. *22* mo. *22* da.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Charles Haupt*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Margaret Webb*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

Filed

AUG 31 1915

191

Chas. M. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*August**29th**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY. That I attended deceased from *August 1st 1915*, to *August 28 1915*, that I saw him alive on *August 28 1915*, and that death occurred, on the date stated above, at *2:00 a. m.*

The CAUSE OF DEATH* was as follows:

M. abnutrition and M. abassimilation(Duration) *1* yrs. *1* mo. *1* da.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. *1* mo. *1* da.(Signed) *J. Boulton* M. D.*Aug. 29, 1915.* (Address) *615 Columbia Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSFERS, OR RECENT RESIDENTS).

At place of death yrs. *1* mo. *16* ds. In the State yrs. *3* mo. *22* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Catholic

DATE OF BURIAL,

Aug 31, 1915

20-UNDERTAKER

M. F. Sons

ADDRESS

606 Lafayette Ave

087859

HEALTH DEPARTMENT—CITY OF BALTIMORE

087859

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

Filed.

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1915, to Aug 29 1915, that I saw her alive on Aug 29 1915, and that death occurred, on the date stated above, at 10 P.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) Edgar B. Friedenwald, M. D.
Aug 29, 1915 (Address) 1616 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 7 mos. 15 ds. In the State yrs. 8 mos. 18 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, COLLEGE OF P. & S.

20-UNDERTAKER

Commissioner Health,

DATE OF BURIAL,

AUG 30 1915

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87860

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

June 14 1915, to Aug 29 1915,
 that I saw h. w. alive on Aug 29 1915,
 and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Alimentary Decomposition
 Chronic cirrhosis of the liver

(Duration).....yrs...2...mos...16...ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs...mos...ds.

(Signed) Edgar B. Friedmann, M. D.

Aug 29, 1915 (Address) 1616 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. 2 mos. 16 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

COLLEGE OF P. & S.

20-UNDERTAKER

Commissioner Health.

DATE OF BURIAL,

AUG 30 1915

ADDRESS

Certified

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *433 S. Bond* ST.; *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *433 S. Bond* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH

November 4th, 1877
(Month) (Day) (Year)

7-AGE

37 yrs. *9* mos. *15* da.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housewife*9-BIRTHPLACE,
(State or Country)*Russia Poland*

10-NAME OF FATHER

Frang Charkowski

11-BIRTHPLACE OF FATHER

(State or Country)

Russia Poland

12-MAIDEN NAME OF MOTHER

Juliaim. Charkowski

13-BIRTHPLACE OF MOTHER

(State or Country)

Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Alfred Charkowski

(Address)

221 S. Broadway

15-

*UG 3 1915**Edmund*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 29th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 29th 1915 to *Aug 29 1915*that I saw her alive on *Aug 29 1915*and that death occurred, on the date stated above, at *12:00 p.m.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)*Reddening of the lungs* (Duration) yrs. mos. da.(Signed) *Alex. A. Sienkiewicz* M. D.*Aug 30 1915* (Address) *221 S. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *Thru work* In the *10* yrs. mos. da. State *10* yrs. mos. da.Where was disease contracted, if not at place of death? *#*

Former or usual residence

433 S. Bond St

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*Hal Rosary Cemetery**Sept 1 1915*

20-UNDERTAKER

ADDRESS

*George J. Ruth**1735 1/2 Oxford Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *230 N. Anny* ST.: *18* WARD)2-FULL NAME *Ella Turner*(Residence in Baltimore: No. *230 N. Anny* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow*
(Write the word.)6-DATE OF BIRTH, *Unknown*, 1
(Month) (Day) (Year)7-AGE, *66* yrs. mos. da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housework*(b) General nature of industry, business, or establishment in which employed (or employer), *At Home*9-BIRTHPLACE, (State or Country), *W.D.*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ella Coster*(Address) *1047 W. Lexington St.*

15-

AUG 31 1915

16-

Chas N. Sinclair
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August - 30*, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 24* 1915 to *Aug 24* 1915, that I saw him alive on *Aug 24* 1915, and that death occurred, on the date stated above, at *12:25* p.m.

The CAUSE OF DEATH* was as follows:

*Acute Intestinal Obstruction*CONTRIBUTORY (Secondary) *Exhaustion*(Signed) *Dr. H. H. H.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Laurel*DATE OF BURIAL, *Sept. 2*, 1915

20-UNDERTAKER

Samuel T. Hemmick ADDRESS *378 W. Biddle St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1806 Aisquith

2-FULL NAME Rose M Collins

(Residence in Baltimore: No. 1806 Aisquith

ST. 9

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

39 St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
6-DATE OF BIRTH, Sept 26, 1876
(Month) (Day) (Year)

7-AGE, 39 yrs. 11 mos. 3 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md

PARENTS.
10-NAME OF FATHER, Hugh Gallagher
11-BIRTHPLACE OF FATHER, Ireland
12-MAIDEN NAME OF MOTHER, Susan O'Leary
13-BIRTHPLACE OF MOTHER, Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt L. Collins

(Address) 1806 Aisquith St.

15-AUG 31 1915 ROBERT E. RAUTEN

Filed 101... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 29, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Elijah J. Russell M. D.
(Coroner.)

Aug 29, 1915 (Address) 423 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Sept 1, 1915

20-UNDERTAKER, Robt J. Turner

ADDRESS, 1442 N Broadway

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

(Month)

(Day)

(Year)

7-AGE

If LESS than

1 day, hrs.,

yrs.

mos.

ds.

or

min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 25, 1915, to, Aug 30, 1915,

that I saw h. alive on Aug 29, 1915,

and that death occurred, on the date stated above, at 5:40 m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

(Duration)

yrs.

mos.

ds.

[Address]

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place
of death

yrs.

mos.

In the
ds. State

yrs.

mos.

ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

18-

Filed

AUG 31 1915

ROBERT J. KRAUTER

MORTAL RECORD CLERK
REGISTRAR

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Franklin Sq. Hos. 15

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Louise Jones.

(Residence in Baltimore: No.

1332 M Mount.

St. 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Black

5-SINGLE,

MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

unknown

(Month)

(Day)

(Year)

7-AGE,

20

yrs.

mos.

da.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

(b) General nature of industry, business, or establishment in which employed (or employer)

Waitress

9-BIRTHPLACE,

(State or Country)

Crisfield, Md.

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER

(State or Country)

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country)

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Geo. G. Snare M.D.

(Address)

Franklin Sq. Hospital

15-

AUG 31 1915

ROBERT

KRAST

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August

(Month)

25

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 16 1915, to Aug 25 1915,

that I saw her alive on Aug 25 1915,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix
uterus
operated on Aug 18 1915

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. G. Snare M. D.

8/25, 1915 (Address) Franklin Sq. Hos.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 8 ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

at Hotel

Former or

usual residence

1332 M Mount St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

PUBLIC CEMETERY.

AUG 31 1915

20-UNDERTAKER

ADDRESS

Commissioner Health,

Per. Wm. E. Woodall

STATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87866

C87866

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Maryland Penitentiary* ST. *10* WARD)

2-FULL NAME *John H. Washington*

(Residence in Baltimore: No. *Maryland Penitentiary* St. *1* yrs. *6* mos. *7* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and NN out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

March - 21, 1882
(Month) (Day) (Year)

7-AGE

33 yrs. *5* mos. *2* ds. or min.?

If LESS than
1 day, hrs.,

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

General Laborer

9-BIRTHPLACE
(State or country)

Washington D. C.

10-NAME OF FATHER

Charles E. Washington

PARENTS

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

Melinda Harris

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John H. Washington
2nd Penitentiary
Address

15-

AUG 31 1915

ROBERT KRAUTER,
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August, 23, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *January - 12, 1915* to *August - 23, 1915*, that I saw him alive on *August - 23, 1915*, and that death occurred, on the date stated above, at *11:20 a.m.*
The CAUSE OF DEATH* was as follows:

Toxemia & Exhaustion

Contributory
(SECONDARY)

(Duration) yrs. mos. ds. *14*
Pulmonary Tuberculosis

(Signed)

William F. Schwartz M. D.
August - 23, 1915 (Address) *Maryland Penitentiary*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *1* yrs. *6* mos. *7* ds. In the State *1* yrs. *6* mos. *7* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Anacostia D. C.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

PUBLIC CEMETERY

AUG 31 1915

20-UNDERTAKER

ADDRESS

Commissioner Health

Wm. E. WOODALL

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *651 W. Lexington* ST.;

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 19.)

2-FULL NAME

(Residence in Baltimore: No. *651 W. Lexington* at

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Nov

(Month)

3

(Day)

1898

(Year)

7-AGE,

56

yrs.

9

mos.

27

ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Blacksmith

9-BIRTHPLACE, (State or Country),

Balt Md

10-NAME OF FATHER,

Samuel Carlisle

11-BIRTHPLACE OF FATHER (State or Country),

Balt Md

12-MAIDEN NAME OF MOTHER

Mary Mocal

13-BIRTHPLACE OF MOTHER (State or Country),

Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Lucia Carlisle

(Address).

651 W. Lexington St

15-

Filed

AUG 31 1915

191

ROBERT . KRAUTER,

Chief Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*August**30**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *August 15* 1915, to *Aug 30* 1915, that I saw him alive on *Aug 29* 1915, and that death occurred, on the date stated above, at *1 P* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(Duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Auto intoxication(Duration) *2* yrs. mos. ds.(Signed) *E. V. Coolahan* M. D.*Aug 31, 1915* (Address) *24 W. Fulton St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*New Cathedral Cem**Sept 15, 1915*

20-UNDERTAKER

ADDRESS

John J. Fulch 1200 W. Lombard St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3122 Presbury* ST. *15* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *3122 Presbury* St. *38* yrs., mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH

Nov 10 1876
(Month) (Day) (Year)

7-AGE

38 yrs. *9* mos. *21* ds.

IF LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Wm C Delcher

11-BIRTHPLACE OF FATHER (State or Country),

Balto

12-MAIDEN NAME OF MOTHER

Mary Baroux

13-BIRTHPLACE OF MOTHER (State or Country),

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15

AUG 31 1915

ROBERT KRAUTER

Filed.....

101.....

MORTAL PERMIT CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 31 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1 1915 to *Aug 31 1915*that I saw her alive on *Aug 30 1915*,and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

*Coronary artery disease**Clinical diagnosis*

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....

Aug 31 1915 (Address) *826 N Carrollton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Western Ave

DATE OF BURIAL,

Sept 1 1915

20-UNDERTAKER

John Cook

ADDRESS

*826 N Carrollton**Dr J M Lumpkin*
826 N Carrollton Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *543 W Barr*)

ST.:

WARD) *22*

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and City and No. 18.)

2-FULL NAME

M. David Harris(Residence in Baltimore: No. *543 W Barr*)St.: yrs. *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

*July 6**1872*

(Month)

(Day)

(Year)

7-AGE,

43

yrs.

1

mos.

25

ds.

If LESS than 1 day.

hrs.

or

min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Can maker*9-BIRTHPLACE,
(State or Country),*Baltimore Md*

10-NAME OF FATHER,

*George W. Hang*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore Md*

12-MAIDEN NAME OF MOTHER

*Elizabeth Holler*13-BIRTHPLACE OF MOTHER
(State or Country),*Balto Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elizabeth Holler*(Address) *543 W Barr St*

15-

AUG. 31 1915

ROBERT . KRAUTER,

Municipal Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Aug**31*, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 23 1915, to *Aug 31* 1915that I saw him alive on *Aug 30* 1915and that death occurred, on the date stated above, at *100* m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic(Duration) *3* yrs. *3* mos. ds.CONTRIBUTORY *Uremia*

(Secondary)

(Duration) yrs. mos. *51* ds.(Signed) *J. M. L. Campbell* M. D.*Aug 31*, 1915 (Address) *821 W. Barr St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

Sept 2, 1915

20-UNDERTAKER

Mrs A Rohde Lane

ADDRESS

730 Pa Ave

887871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH
CITY OF BALTIMORE (No. 104. Albernade

FULL NAME
Wlad Ulinakar
(Residence in Baltimore: No. 104. Albernade St.

ST. 3 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 6 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male
4-COLOR OR RACE. white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
6-DATE OF BIRTH. unknown
7-AGE. 60 yrs. 11 mos. 1 day

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. laborer
(b) General nature of industry, business, or establishment in which employed (or employer). General.

9-BIRTHPLACE. (State or Country). Russia

PARENTS.
10-NAME OF FATHER. unknown
11-BIRTHPLACE OF FATHER (State or Country). unknown
12-MAIDEN NAME OF MOTHER. unknown
13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant).....
(Address).....

15- AUG 31 1915
ROBERT KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 19, 1915
17-I HEREBY CERTIFY, That I took charge of the remains described above, held in (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:

Natural causes.
(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration)..... yrs. mos. ds.
(Signed) Wm. M. Semper, M. D. Aug 24 1915 (Address) 174 Madison St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. PUBLIC CEMETERY. DATE OF BURIAL. AUG 31 1915

20-UNDERTAKER. Commissioner Health, ADDRESS

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 21

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs.; mos.; ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

AUG 31 1915

ROBERT

KRAUTER,

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17 I HEREBY CERTIFY, That I attended deceased from

Aug 28 1915 to Aug 28 1915,

that I saw her alive on Aug 28 1915,

and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

General Sepsis (from infected umbilicus)

(Duration) yrs.; mos.; ds.

CONTRIBUTORY (Secondary)

(Duration) yrs.; mos.; ds.

(Signed) M. D.

8/28, 1915 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs.; mos.; ds. In the State yrs.; mos.; ds.

Where was disease contracted, if not at place of death? 1023 Parkview St.

Former or usual residence 1023 Parkview St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

UNIVERSITY OF MARYLAND AUG 31 1915

20-UNDERTAKER Commissioner Health.

ADDRESS

FOR ANATOMICAL PURPOSES

C87873

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *St Joseph Hospital*)ST.: *9*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

a-FULL NAME *Lena Huffer*(Residence in Baltimore: No. *1002 Belvedere Ave (Balt Co)* St.: *50* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Unknown, *1*

(Month)

(Day)

(Year)

7-AGE,

57

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*House work*

9-BIRTHPLACE, (State or Country),

MD

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thomas Huffer*(Address) *1002 Belvedere*

15-

Filed

AUG 31 1915

191

ROBERT

F. KRAUTER,

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 29th, 1915.
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Accident (Automobile)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Elijah J. Russell* M. D.*Aug 30th*, 1915. (Address) *423 N Broadway*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *20 minutes* in the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1002 Belvedere Ave*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL:

Woodlawn Cem *Sept 1, 1915*

20-UNDERTAKER

ADDRESS

Ed Roy Stippler *844 N 36 St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 838 Peach Alley

St. 22 WARD

REGISTERED NO. C

2-FULL NAME Mary ee Goodman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 838 Peach Alley

St.; yrs., 1 mon. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE, Colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)
6-DATE OF BIRTH, July 11, 1915 (Month) (Day) (Year)

7-AGE, 1 21 If LESS than 1 day, ... hrs. or ... min. (Month) (Day) (Year)

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER, Isaac Goodman

11-BIRTHPLACE OF FATHER (State or Country),

Va

12-MAIDEN NAME OF MOTHER

Annie Riley

13-BIRTHPLACE OF MOTHER (State or Country),

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Goodman

(Address) 838 Peach Alley

15-

Filed 1915 191

Char M. Sinclair Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 31, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Asphyxia

(In bed with Mother)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

Aug 31, 1915. (Address) 517 Scott St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

West Auburn Ct

Sept 1st, 1915

20-UNDERTAKER

ADDRESS

J. L. Thompson 108 W. Madison

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1614 E Fort Ave* ST. *24*)

2-FULL NAME *John D. Stegman*

(Residence in Baltimore: No. *1614 E Fort Ave*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *11* mos. *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Married
(Write the word.)

6-DATE OF BIRTH.

August 3, 1848
(Month) (Day) (Year)

7-AGE.

67 yrs. *78* mos. *11* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Walter Keeper
Clerk

9-BIRTHPLACE.

(State or Country).

Germany

10-NAME OF FATHER.

John Stegman

11-BIRTHPLACE OF FATHER.

(State or Country).

Germany

12-MAIDEN NAME OF MOTHER.

Not known

13-BIRTHPLACE OF MOTHER.

(State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frederic B. Stegman*

(Address) *1614 E Fort Ave*

15-

SEP 1 1915

ROBERT K. KRACER

BALTIMORE PORTAL CLERK

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 31, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Infantile Chorea

(Duration) *4* yrs. *4* mos. *11* ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs. *1* mos. *11* ds.

(Signed) *Edmund J. ...* M. D. (Coroner.)

Aug 31, 1915 (Address) *1614 E Fort Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *11* yrs. *78* mos. *11* ds. In the State *11* yrs. *78* mos. *11* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

London Park

DATE OF BURIAL.

Sept 2 1915

20-UNDERTAKER

William Croft

ADDRESS

502 E Fort Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *2938 E Baltimore* ST.: *6* WARD)

2-FULL NAME *Anna Miller*

(Residence in Baltimore: No. *27 W. Hare St.*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. *17* mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX, *Female*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow*
(Write the word.)
6-DATE OF BIRTH, *Aug 31, 1849*
(Month) (Day) (Year)

7-AGE, *65 yrs. 11 mos. 28 ds.*
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balto Md*

PARENTS.
10-NAME OF FATHER, *John C. Seitz*
11-BIRTHPLACE OF FATHER (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER, *Unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Kraft*
(Address) *27 W. Hare St.*

15- *SEP - 1 1915* ROBERT J. KRAUTER, Registrar.
Filed *1915* Burial Permit Officer

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 29, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Accident) Fall from Street Car
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) *Shock*
(Duration) ... yrs. ... mos. ... ds.

(Signed) *Elyah J. Russell* M. D. (Coroner.)
Aug 31, 1915 (Address) *423 N Broadway*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Gen* DATE OF BURIAL, *Sept 24, 1915*
20-UNDERTAKER, *J. Sander Sons* ADDRESS, *1710 Pratt*

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *Mercy Hospital* ST. *1* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Annie Birner*
(Residence in Baltimore: No. *231 S. Madenia St.* St.; yrs. *4 1/2* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single* (Write the word.)
6-DATE OF BIRTH. *November 2, 1896* (Month) (Day) (Year)
7-AGE. *18* yrs. *9* mos. *27* ds. IF LESS than 1 day,hrs. ormin.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Factory-worker*
(b) General nature of industry, business, or establishment in which employed (or employer). *In factory*

9-BIRTHPLACE. (State or Country), *City*

10-NAME OF FATHER, *John S. Birner*
11-BIRTHPLACE OF FATHER (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER, *Kunigunda Kratz*
13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *John S. Birner*
(Address) *231 S. Madenia St.*

15- *SEP - 1 1915* 101. *ROBERT KRAUTER* Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 29, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows:
suicide - carbolic acid by mouth
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) *W. H. Chambers* M. D. (Coroner.)
Aug. 31, 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place *10 minutes* In the of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?
231 S. Madenia St.
Former or usual residence. *231 S. Madenia St.*

19-PLACE OF BURIAL OR REMOVAL, *Mount Carmel* DATE OF BURIAL, *Sept. 1, 1915*

20-UNDERTAKER, *H. Sander & Sons* ADDRESS, *1710 Reister St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 926 Little Pine street, ST. 17 WARD)

FULL NAME Agnes Riley,

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 926 Little Pine street, St. (yrs., 30 mos. ds.))

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE. Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widowed, (Write the word.)

6-DATE OF BIRTH. Unknown, 1870 (Month) (Day) (Year)

7-AGE. 45 yrs. 2 mos. 7 ds. If LESS than 1 day. ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Laundress, (b) General nature of industry, business, or establishment in which employed (or employer). at home,

9-BIRTHPLACE. (State or Country), Washington, D. C.

10-NAME OF FATHER. William Riley, 11-BIRTHPLACE OF FATHER (State or Country), Maryland, 12-MAIDEN NAME OF MOTHER. Helen Stewart, 13-BIRTHPLACE OF MOTHER (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant). Mary Bouldin, daughter, (Address). 936 Little Pine street.

15- SEP - 1 1915 ROBERT A. KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 30th., 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease, (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds. (Signed) Frederick Hempel, M. D. (Coroner.) Aug. 30, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death. ... yrs. ... mos. ... ds. In the State. ... yrs. ... mos. ... ds. Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cemetery, DATE OF BURIAL. Sept. 2, 1915, ADDRESS. Robert A. Elliott, 506, Rogers' line.

Important. See instructions on back of certificate.

87879

HEALTH DEPARTMENT--CITY OF BALTIMORE

87879

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 537 W. Preston

ST. 17

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Wm Spriddle

(Residence in Baltimore: No.

537 W. Preston

St. 57 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Unknown 1858

7-AGE

57

yrs.

mos.

ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Coachman

9-BIRTHPLACE

(State or country)

Md. Balto.

10-NAME OF FATHER

John Spriddle

11-BIRTHPLACE OF FATHER
(State or country)

Md.

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER
(State or country)

Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah Y. Spriddle

(Address)

537 W. Preston St.

15-

SEP - 1 1915

ROBERT . KRAUTER

Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

August 31, 1915

17- I HEREBY CERTIFY, That I attended deceased from July 19, 1915, to August 31, 1915, that I saw him alive on August 30, 1915, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH was as follows:

Acute Gastro Enteritis

Since July 19th 1915

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) H. K. Gonnely M. D.

Aug 31, 1915 [Address] 117 W. Saratoga St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

W. H. C. Cemetery

Sept. 2, 1915

2-UNDERTAKER

Robert A. White

ADDRESS

506 N. Rogers Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

087880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *622 N. Calvert* ST.; *11* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *622 N. Calvert St.*St.; *1* yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May 22,

(Month)

(Day)

1898
(Year)

7-AGE,

17 yrs. *9* mos. *9* da.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. T. Berg (Mother)*(Address) *622 N. Calvert St.*

15 SEP - 1 1915

Filed..... 191.....

ROBERT J. KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 31,

(Month)

(Day)

1915
(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 10 1915, to *Aug 31* 1915,that I saw her alive on *Aug 31* 1915,and that death occurred, on the date stated above, at *2 P.m.*

The CAUSE OF DEATH* was as follows:

*Pneumonia**intercurrent*

..... (Duration)..... yrs. mos. da.

CONTRIBUTORY
(Secondary)*Pneumonia* (Duration)..... yrs. mos. *25* da.(Signed) *Robert C. Nitch* M. D.*Aug 31* 1915. (Address) *2500 Ashbur St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Catharine's *Sept 3* 1915

20-UNDERTAKER

Mr. A. Paulus *Catharine*

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *727 W. West*)ST. *21*

WARD)

2-FULL NAME

Annie E. Gassaway

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *727 W. West*)St. *1* yrs. *10* mos. *25* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR FORCED (Write the word) *Single*

6-DATE OF BIRTH *Oct. 6, 1913*
(Month) (Day) (Year)

7-AGE *1* yrs. *10* mos. *25* ds. or — min.?

IF LESS than 1 day, — hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

*None*9-BIRTHPLACE
(State or country)*Baltimore Md*

PARENTS

10-NAME OF FATHER

*Harry A. Gassaway*11-BIRTHPLACE OF FATHER
(State or country)*Md - Balt.*

12-MAIDEN NAME OF MOTHER

*Annie E. Long*13-BIRTHPLACE OF MOTHER
(State or country)*Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harry Gassaway*(Address) *727 W. West St*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug. 31, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug. 29, 1915*, to *Aug. 30, 1915*, that I saw her alive on *Aug. 30, 1915*, and that death occurred, on the date stated above, at *4 A. M.* The CAUSE OF DEATH* was as follows:

Cholera Infantum(Duration) yrs. mos. *3* dsContributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *John J. Smith*

M. D.

Aug. 31, 1915 (Address) *717 N. Carroll St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-NAME OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mt. Olivet Cem**Sept 2, 1915*

20-UNDERTAKER

ADDRESS

*W. J. McKelvey**Pennix Park*

SEP - 1 1915

ROBERT . KRAUTER,

Burial Permit Clerk
REGISTRAR

State of Maryland, Baltimore, City, Health Department, is very important. See instructions on back of certificate.

087882 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104
REGISTERED No. C.

1-PLACE OF DEATH

2-CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (If write the word.)

Single

6-DATE OF BIRTH.

Mar

1

1914

(Month)

(Day)

(Year)

7-AGE.

1 6

yr. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Work

9-BIRTHPLACE, (State or Country).

Maryland

10-NAME OF FATHER.

Marion Stone

11-BIRTHPLACE OF FATHER (State or Country).

Russia

12-MAIDEN NAME OF MOTHER

Annie Steinberg

13-BIRTHPLACE OF MOTHER (State or Country).

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mar Stone

(Address)

2454 Druid Hill Ave.

15-

Filed 1 1915

1915

Chas M. McClure

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept

1, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Harold E. Hight

Sept 1, 1915

(Coroner)

36 W. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.

Balto Hebrew

DATE OF BURIAL.

Sept 1, 1915

20-UNDERTAKER

J. Ahrens & Co

ADDRESS

1611 Mad Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *On way St Joseph Hospital*)

2-FULL NAME

Margaret Pabeling

(Residence in Baltimore: No. *Wilkes Ave Parkville Bldg Co. Md*)

REGISTERED NO. C

ST. *9*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *76* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*
6-DATE OF BIRTH, *Feb 8th, 1839*
(Month) (Day) (Year)

7-AGE, *76* yrs., *6* mos., *22* ds. 12 LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *none*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *md*

PARENTS.
10-NAME OF FATHER, *Henry Decker*
11-BIRTHPLACE OF FATHER (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER, *unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Marcus Kirsten*

(Address) *Parkville, Bldg Co. Md*

15- SEP - 1 1915 ROBERT . KRAUTER,

Filed....., 191..Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 30th, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-
topsy or inquiry.)

and that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Elyah J. Russell* M. D.

Aug 31st, 1915 (Address) *423 N. Broadway*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer Cemetery*

DATE OF BURIAL, *Sept 3rd, 1915*

20-UNDERTAKER, *Henry Horch & Son*

ADDRESS, *1301 E Bay St*

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87881

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 E Chase ST.; 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 829 E Chase St. St.; Five yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED, single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 23rd 1883
(Month) (Day) (Year)

7-AGE,

322 yrs. 7 mos. 1 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...None9-BIRTHPLACE,
(State or Country),Balta Ind.

10-NAME OF FATHER,

Thomas Foss11-BIRTHPLACE OF FATHER
(State or Country),Balta Ind.

12-MAIDEN NAME OF MOTHER

Jane Smith13-BIRTHPLACE OF MOTHER
(State or Country),Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Thomas Foss

(Address)

829 E Chase St.

35-

SEP - 1 1915

HARRY G. ADAMS

Filed

191..E..1st..P..1st..0191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 30th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 15 1914, to Aug 30 1915, that I saw her alive on Aug 29 1915, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane
(Duration) 6 yrs. 6 mos. 1 ds.

CONTRIBUTORY (Secondary)

Paranoid
(Duration) 5 yrs. 5 mos. 1 ds.(Signed) John J. Foss M. D.
Sept 1 1915 (Address) 936 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

Sept 2, 1915

20-UNDERTAKER

John A. Moran

ADDRESS

Bank & Ann St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq Hos.* ST.; *14* WARD)

REGISTERED NO. C

FULL NAME *Ella Robertson*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1716 John*St.; *42* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Aug.

(Month)

(Day)

1873
(Year)

7-AGE,

42

yrs. mos. ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Saleslady*
Dept Store

9-BIRTHPLACE,

(State or Country),

Balta Md.

10-NAME OF FATHER,

Thomas Robertson

11-BIRTHPLACE OF FATHER

(State or Country),

Balta Md

12-MAIDEN NAME OF MOTHER

Cornelia Robinson

13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm Walters

(Address)

1716 John St.

15-

SEP - 1 1915

HARRY O. ANDREWS,

Filed

191

REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug

(Month)

(Day)

31, 191*5*
(Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 30 1915*, to *Aug 31 1915*, that I saw her alive on *Aug 31 1915*, and that death occurred, on the date stated above, at *6 P. m.*

The CAUSE OF DEATH* was as follows:

Epicoma of uterus
with ovarian cysts.
Aug 31 '15 (Duration) *1* yrs. *8* mos. *1* ds.

CONTRIBUTORY (Secondary)

Surgical shock.

(Signed)

Geo. H. Green M. D.

8/31, 1915 (Address)

Franklin Sq Hos

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

at Home

Former or usual residence

1716 John St.

19-PLACE OF BURIAL OR REMOVAL,

St Olivet

DATE OF BURIAL,

Sept 2 1915

20-UNDERTAKER

John A. Moran & Amst

ADDRESS

Bank

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No.

3336 Old Frederick St.

WARD) 20

2-FULL NAME

Elizabeth K. Volker

(If death occurred in a hospital or institution, give its NAME instead of street and number and file cut No. 18.)

(Residence in Baltimore: No.

3336 Old Frederick St.

St. 48 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female White

4-COLOR OR RACE

MARRIED married
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

April 9, 1847
(Month) (Day) (Year)

7-AGE

68 4 23
yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE
(State or country)

Germany

PARENTS

10-NAME OF FATHER

Eliot Scherles

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Elizabeth Eschleib

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

August J. Volker

(Address)

3336 Old Frederick St.

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

September 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 31, 1915, to, September 1, 1915,
that I saw him alive on September 1, 1915,
and that death occurred, on the date stated above, at 2:00 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Distention

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Henry J. Hahn M. D.

Sept 1, 1915 (Address) 508 Park Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park

Sept 23, 1915

20-UNDERTAKER

ADDRESS

Mrs. A. Paulus

Catharine

15-SEP - 1 1915
Filed

Marital Permit Clerk

REGISTRAR

C87887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital*)

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *University Hospital*)

St.: yrs. mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, *Married*,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Aug. 31, 1884
(Month) (Day) (Year)

7-AGE,

31 yrs. mos. da.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Laborer*9-BIRTHPLACE,
(State or Country),*Maryland*

PARENTS.

10-NAME OF FATHER,

*Columbus Sueso*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Montha Jenkins*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Dr. H. S. Coleman*(Address) *University Hospital*

15-

SEP - 1 1915

Filed

191

HARRY O. ANDREWS

Marial Park, D.C.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 31, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug. 24, 1915*, to *Aug. 31, 1915*, that I saw him alive on *Aug. 31, 1915*, and that death occurred, on the date stated above, at *6:35 A.M.*

The CAUSE OF DEATH* was as follows:

Typhoid Fever(Duration) *Unknown*CONTRIBUTORY
(Secondary)*None*(Duration) *Unknown*(Signed) *H. S. Coleman* M. D.*8/31, 1915* (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the *Life* State yrs. mos. da.Where was disease contracted, if not at place of death? *Unknown*Former or usual residence *Hughesville Md.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hughesville Md. *Sept 7, 1915*

20-UNDERTAKER

ADDRESS

John Cook *1003 1/2 S. 1st St.*

C87888

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87888

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hosp.* ST.: *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *University Hospital* St.: yrs., mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*white*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown, 1901
(Month) (Day) (Year)

7-AGE,

14 yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... *Child*(b) General nature of industry, business, or establishment in which employed (or employer)..... *School*9-BIRTHPLACE,
(State or Country),*Ind.*

10-NAME OF FATHER,

*Wm B. Evans*11-BIRTHPLACE OF FATHER
(State or Country),*Ind*

12-MAIDEN NAME OF MOTHER

*Clara Bradshaw*13-BIRTHPLACE OF MOTHER
(State or Country),*Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *H. H. Bradshaw*(Address)..... *Cristfield Ind*

15-SEP - 1 1915

HARRY O. ANDREWS

Filed..... 191..... *Marial. Peralt. Oler*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 1, 191*5*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 1 191*5*, to *Sept 1* 191*5*,that I saw him alive on *Sept 1* 191*5*,and that death occurred, on the date stated above, at *3:45 pm*.

The CAUSE OF DEATH* was as follows:

Pertussis(Duration)..... yrs. mos. *3* ds.CONTRIBUTORY..... *As appendicitis*
(Secondary)(Duration)..... yrs. mos. *3* ds.(Signed)..... *W. Houston Boulton* M. D......, 191... (Address) *Univ. Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. *1* ds. In the *14* yrs. mos. ds.Where was disease contracted, *Well, Smiths Island*
If not at place of death?.....Former or usual residence..... " " " *Ind*

19-PLACE OF BURIAL OR REMOVAL,

Cristfield Ind.

DATE OF BURIAL,

Sept 2, 191*5*

20-UNDERTAKER

E. B. Harle

ADDRESS

115 E. Heat St.

C87889 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 Friendsbury ST.; 15 WARD)170 C87889
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Frederick Reese(Residence in Baltimore: No. 1702 FriendsburySt.; 72 yrs., 5 mos., 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

March 31 1843
(Month) (Day) (Year)

7-AGE,

72 yrs., 5 mos., 1 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Carpenter9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Annie V. Reese
(Address) 1702 Friendsbury St.

15-

SEP - 1 1915

HARRY O. ALLARD,

Filed

Marital Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 1, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 10th 1915, to August 31st 1915, that I saw him alive on August 31st 1915, and that death occurred, on the date stated above, at 5:45 am.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis
of the Liver(Duration) 9 yrs., 9 mos., — ds.CONTRIBUTORY
(Secondary)Chronic Intestinal Hepatitis(Duration) 2 yrs., — mos., — ds.(Signed) H. M. J. Sullivan M. D.Sept. 1st 1915, (Address) 1702 Friendsbury St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

National Cem Sept. 3rd 1915

20-UNDERTAKER

ADDRESS

Charles P. Evans & Son 1181 Mt Royal Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1007 N Wolfe* ST. *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1007 N Wolfe St* *25* yrs. *3* mos. *25* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>married</i> (Write the word.)
6-DATE OF BIRTH, <i>June 29</i> , <i>1849</i> (Month) (Day) (Year)		
7-AGE <i>66</i> yrs. <i>2</i> mos. <i>2</i> ds.		8-LESS than 1 day. ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housekeeping*9-BIRTHPLACE,
(State or Country),*Austria*

PARENTS.

10-NAME OF FATHER,

*Not Known*11-BIRTHPLACE OF FATHER
(State or Country),*Not Known*

12-MAIDEN NAME OF MOTHER

*don't know*13-BIRTHPLACE OF MOTHER
(State or Country),*Austria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*Louisa M. Hamara*.....(Address).....*1007 N. Wolfe St.*.....

15-

SEP - 1 1915. HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 31, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *August 27*, *1915*, to *August 31*, *1915*, that I saw her alive on *August 31*, *1915*, and that death occurred, on the date stated above, at *7:30 A* m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Catarrhal)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Exposure to Cold and general debility(Signed).....*Thos. J. Lyons*.....M. D......, 191... (Address).....*1007 N. Wolfe St.*.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Hill

DATE OF BURIAL,

Sept 3, *1915*

20-UNDERTAKER

Frank Croach Son

ADDRESS

1904 Ashland St.

C87892

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87892

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

REGISTERED NO. C

FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed

191

HARRY O. ANDREWS

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said.

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Accident - Wood alcohol poisoning

Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Signed)

(Coroner)

Sept 1, 1915 (Address) 18 W. Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNIVERSITY

ADDRESS

Important. See instructions on back of certificate.

THIS CARD OF DEATH IS PLAIN TEXT, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87893

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87893

PLACE OF DEATH

79 REGISTERED No. C

CITY OF BALTIMORE (No. 1700 Warwick Ave. 15 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Engel

(Residence in Baltimore: No. 1700 Warwick Ave. St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

6-DATE OF BIRTH Sept. 21, 1864 (Month) (Day) (Year)

7-AGE 50 11 10 If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Carpenter (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Pittsburg Pa

10-NAME OF FATHER John C Engel

11-BIRTHPLACE OF FATHER Germany.

12-MAIDEN NAME OF MOTHER Eliz. Rheinhardt

13-BIRTHPLACE OF MOTHER Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gussie Engel

(Address) 1700 Warwick Ave.

15 SEP - 1 1915 BARRY O. ANDREWS, Marial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug 31, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6, 1915, to Aug 31, 1915, that I saw him alive on Aug 31, 1915, and that death occurred, on the date stated above, at 8:15 P. M. The CAUSE OF DEATH* was as follows:

Chron. Endocarditis

(Duration) Unknown

Contributory (SECONDARY) General Anasarca

(Duration) 3 yrs. mos. ds.

(Signed) Chas. C. Conner M. D. 9/1, 1915 (Address) 1101 N. Fullon Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Western Park

DATE OF BURIAL Sep 3, 1915

20-UNDERTAKER W. Cook

ADDRESS 301 E. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87894

C87894

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hosp* ST. *9* WARD)

2-FULL NAME

(Residence in Baltimore: No. *713 E. 71st St.* St. *10* yrs. *10* mos. *10* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Aug 27, 1905
(Month) (Day) (Year)

7-AGE,

10 yrs. *5* mos. *5* ds.

If LESS than 1 day,hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*School girl*

9-BIRTHPLACE, (State or Country),

Balt. Md.

10-NAME OF FATHER,

John J. Daily

11-BIRTHPLACE OF FATHER (State or Country),

Balt. Md.

12-MAIDEN NAME OF MOTHER

Ellen B. Anderson

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John J. Daily*(Address) *713 E. 71st St.*

15-

Filed.....

191.....

MARIAL PERMIT...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 1, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Aug 29* 1915, to *Sept 1* 1915, that I saw her alive on *Sept 1* 1915, and that death occurred, on the date stated above, at *8:40 P.M.*

The CAUSE OF DEATH* was as follows:

Scarlet Fever
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Toxemia
(Duration).....yrs.....mos.....ds.
(Signed) *J. H. P. Galt* M. D.
Sept 1, 1915 (Address) *St Josephs Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos. *4* ds. In the *10* yrs.mos.ds.

Where was disease contracted, if not at place of death?

Unknown

Former or usual residence

713 E. 71st St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery....., 191.....

20-UNDERTAKER

ADDRESS

John J. Anderson *113 N. W. Ave.*

3 P.M.O.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Joseph Hospital

ST. 5 WARD)

2-FULL NAME

Marion Burns

(Residence in Baltimore: No.

1239 Jefferson St. -

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single.

6-DATE OF BIRTH,

June 2, 1848
(Month) (Day) (Year)

7-AGE,

67 yrs. 3 mos. ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE, (State or Country),

Liverpool England

10-NAME OF FATHER,

Patrick Burns

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Bridget Flanagan

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas V. Ligh

(Address) 1239 Jefferson St.

15-

SEP - 2 1915

Filed

ROBERT KRAUTER

Official Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 24 1915, to Sept. 1 1915, that I saw her alive on Sept 1 1915, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Clinical diagnosis
Cerebral hemorrhage
not known
(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary)

hypertension
(Duration)yrs.mos.ds.(Signed) O. W. Hubbard M. D.
Sept. 1, 1915 (Address) St. Joseph Hospital

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? not known

Former or usual residence 1239 Jefferson St.

19-PLACE OF BURIAL OR REMOVAL,

New-Cathedral Cem.

DATE OF BURIAL,

Sept. 3, 1915

ADDRESS

McCormick - Carroll 608 4 Potomac St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (NO. 1)

2-FULL NAME

William Tybuck

(Residence in Baltimore: No. 1111 S. Streeper

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 33 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

Aug 20th

1882

7-AGE,

33

—

8

da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Marine

(b) General nature of industry, business, or establishment in which employed (or employer).

Engineer

9-BIRTHPLACE,

(State or Country),

Balto. Md.

10-NAME OF FATHER,

George Tybuck

11-BIRTHPLACE OF FATHER

(State or Country),

Born at Sea

12-MAIDEN NAME OF MOTHER

Magdalena Biston

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

George Tybuck

(Address),

1111 S. Streeper St.

15-

Filed

SEP - 2 1915

191

ROBERT J. KRAUTER,

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 28th

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) J. J. Jones

(Coroner)

M. D.

Sept. 1st, 1915

(Address)

316 Orville St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

Mount Carmel

DATE OF BURIAL,

Sept. 2nd, 1915

20-UNDERTAKER

Lilly Ziller

ADDRESS

403 S. Wolfe St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *4* WARD)

2-FULL NAME

(Residence in Baltimore: No. *University Hospital* St.; yrs. mos. *8* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White Norwegian*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) *Single*

6-DATE OF BIRTH,

Unknown, 1889
(Month) (Day) (Year)

7-AGE,

26

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Sailor

9-BIRTHPLACE, (State or Country),

Kragers Norway

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *British Consulate*

(Address)

15-

SEP - 2 1915

ROBERT KRAUTER

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 24 1915, to *Sept 1* 1915,that I saw h/w alive on *Sept 1* 1915,and that death occurred, on the date stated above, at *5:30* a.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever(Duration) yrs. mos. *12* ds.

CONTRIBUTORY (Secondary)

Pneumonia(Duration) yrs. mos. *1* ds.(Signed) *W. J. Gandy* M. D.*Sept 2*, 1915. (Address) *Univ. Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *8* ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? *On board SS Eridviken*Former or usual residence *Norway*

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill

DATE OF BURIAL,

Sept. 2, 1915.

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 W. Balt.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 22 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP - 2 1915

ROBERT J. KRAUTER,

191. Serial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Autopsy & Inquest*
(Inquest, autopsy or inquest.)thereon and from the evidence obtained by said *Autopsy & Inquest*
(Inquest, autopsy or inquest.)

that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strains - Strangulation by mouth.(Duration) *10 minutes* yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Thos. R. Kaubert* M. D.
(Coroner)Sept. 1, 1915 (Address) *18 N. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cem. *Sept. 2, 1915.*

20-UNDERTAKER,

ADDRESS

John Trebilianckas 500 S. Pica St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *22*)

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *9 W. Montgomery* St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Dec. 3, 1848
(Month) (Day) (Year)

7-AGE.

*66 yrs., 8 mos., 2 ds.*If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Watchman*
B. O. A. Wharf

9-BIRTHPLACE.

(State or Country).

Md.

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert Krauth*(Address) *Calvert St.*

15-

ROBERT A. KRAUTH

SEP - 2 1915

Sur. & Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 1, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

*Aug 3, 1915, to Sept 1, 1915*that I saw him alive on *Sept 1, 1915*and that death occurred, on the date stated above, at *8:00 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(no operation)
(Duration) *2 mos., 2 wks., 2 ds.*

CONTRIBUTORY (Secondary)

(Signed) *Edward J. Smith, M.D.*
Sept 1, 1915 (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *29* yrs., *29* mos., *29* ds. In the *State* *Md.*Where was disease contracted, if not at place of death? *9 W. Montgomery St.*Former or usual residence *9 W. Montgomery St.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cave St. Calvert Co Md. Sept. 4, 1915

20-UNDERTAKER

ADDRESS

J. E. Craus & Son *144 S. Charles*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Swynis Falls near Edmondson* ST.; *164* WARD) *164*

FULL NAME

Carl Herman Sales

(Residence in Baltimore: No. *164 Calverton Road*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)

6-DATE OF BIRTH,

June 14th, 1908
(Month) (Day) (Year)

7-AGE,

7 yrs. *2* mos. *17* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

School

9-BIRTHPLACE,

(State or Country),

Balto. Md

10-NAME OF FATHER,

Charles Sales

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Martha Goette

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Martha Sales

(Address)

164 Calverton Rd.

15-

SEP - 2 1915

ROBERT KRAUTER

Filed

Baltimore Health Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 30th, 1915.
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*
(Inquest, au-

Inquiry find that said deceased came to *his* death
topsy or inquiry on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Samuel Winkler M. D.

(Coroner)

Aug 31st 1915 (Address) *2302 Madison Ave*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Trinity Cemetery

DATE OF BURIAL,

Sept 2, 1915

20-UNDERTAKER

George L. Schwa & Bro. 2101 Frederick Ave.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87901

CERTIFICATE OF DEATH.

170
REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *802 E. Fort Ave.* ST.; *24* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *802 E. Fort Ave.*St.; *40* yrs., *1* mos. *2* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

July

(Month)

26

(Day)

1870

(Year)

7-AGE,

45

yrs.

1

mos.

6

ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

*P.R.
Conductor*

9-BIRTHPLACE,

(State or Country),

West Virginia

10-NAME OF FATHER,

Geo. W. Hoff, Jr.

11-BIRTHPLACE OF FATHER

(State or Country),

W. Va.

12-MAIDEN NAME OF MOTHER

Sallie Hiltz

13-BIRTHPLACE OF MOTHER

(State or Country),

W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Mary V. Hoff

(Address)

802 E. Fort Ave.

15-

SEP - 2 1915

Filed

191

ROBERT . KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Sept.**2**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 30 191*5*, to *Sept. 1* 191*5*,that I saw him alive on *Sept. 1* 191*5*,and that death occurred, on the date stated above, at *2:40* a.m.

The CAUSE OF DEATH* was as follows:

*Chronic myocardial**hypertrophy*(Duration) *1* yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. S. ...

M. D.

Sept. 2, 191*5*. (Address) *802 E. Fort Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Bur.

DATE OF BURIAL,

9/4, 191*5*.

20-UNDERTAKER

J. F. ...

ADDRESS

39 E. Fort Ave.

C87902

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87902

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 2136 Division street, ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Henry Johnson and Gertie Hungerford

(Residence in Baltimore: No. 2136 Division street, St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male,	4-COLOR OR RACE, Colored,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single,
6-DATE OF BIRTH, August 29th, 1915. (Month) (Day) (Year)		
7-AGE, 0 yrs. 0 mos. 2 ds.		It LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work.....None. (b) General nature of industry, business, or establishment in which employed (or employer).....		

9-BIRTHPLACE, (State or Country), Baltimore, Md.
10-NAME OF FATHER, Henry Johnson,
11-BIRTHPLACE OF FATHER (State or Country), Virginia,
12-MAIDEN NAME OF MOTHER Gertie Hungerford,
13-BIRTHPLACE OF MOTHER (State or Country), Virginia,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gertie Hungerford, mother,
(Address) 2136 Division street,

15- SEP - 2 1915 ROBERT . KRAUTH, Registrar.
Filed..... 191. Burial Permit Over

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH,
August 31st, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Prematurity,
((cause unknown))

(Duration) yrs. mos. ds.

CONTRIBUTORY 8 months utero-gestation
(Secondary)

(Duration) yrs. mos. ds.
(Signed) Frederick Hempel, M. D.
(Coroner.)

Sept. 1, 1915. (Address) 3310 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

COLLEGE OF P. & S.

20-UNDERTAKER

ADDRESS

Commissioner Health.

Per. Wm E. WOODALL.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87903

CERTIFICATE OF DEATH.

109
REGISTERED NO. C

C87903

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *922 E. Pratt.* ST.; *3* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *922 E. Pratt.* St.; *3* yrs., — mos. — ds.)*Antonina Mugowska*

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOW,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

Sept. Know, 1850
(Month) (Day) (Year)

7-AGE,

About 65 yrs. — mos. — ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*None**A. Home*9-BIRTHPLACE,
(State or Country),*Russia*

10-NAME OF FATHER,

*Don't Know*11-BIRTHPLACE OF FATHER
(State or Country),*Don't Know*

12-MAIDEN NAME OF MOTHER

*Don't Know*13-BIRTHPLACE OF MOTHER
(State or Country),*Don't Know*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Leonardo Grodzinski*(Address) *922 E. Pratt St.*

15-

SEP - 2 1915 HARRY O. ANDREWS,
Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Sept 1st 1915, to Sept 2nd 1915,*that I saw h^e alive on *Sept 1st 1915,*and that death occurred, on the date stated above, at *9 A. M.*

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) *A. F. Rues* M. D.*Sept 2nd 1915.* (Address) *245 Bury*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary.

DATE OF BURIAL,

Sept 3, 1915.

20-UNDERTAKER

William Fialkowski

ADDRESS

1618 Eastern Ave.

C87904

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87904

CERTIFICATE OF DEATH

30

PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 835 E Chase St. ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Francis X. Quinn(Residence in Baltimore: No. 835 E Chase St. St. 2 yrs. 7 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male White

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Single

6-DATE OF BIRTH

November

(Month)

3

(Day)

1912

(Year)

7-AGE

2

yrs.

7

mos.

28

ds.

or

1 day,

hrs.

If LESS than

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)None9-BIRTHPLACE
(State or country)Baltimore Md.

10-NAME OF FATHER

John J. Quinn11-BIRTHPLACE OF FATHER
(State or country)Baltimore Md.

12-MAIDEN NAME OF MOTHER

Ellen C. Callahan13-BIRTHPLACE OF MOTHER
(State or country)Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John J. Quinn

(Address)

835 E Chase St.

15-

SEP - 2 1915

191

HARRY O. ANDREWS,
Marial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sep 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 7th, 1915, to, Sept 1, 1915,that I saw him alive on Aug 31st, 1915,and that death occurred, on the date stated above, at 5-2 m.

The CAUSE OF DEATH* was as follows:

Intracranial MeningitisContributory (SECONDARY) Pneumonia (Duration) yrs. 4 mos. 4 ds.Casum Softening (Duration) yrs. 2 mos. 24 ds.(Signed), Edmund J. Quinn M. D.Sept 1, 1915 [Address] 208 Avenue

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cathedral Cemetery

DATE OF BURIAL

Sept 3, 1915

20-UNDERTAKER

Henry H. McKee & Son

ADDRESS

805 N Calvert St

TION Every Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87906

CERTIFICATE OF DEATH.

x 109

C87906

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *St Josephs Hosp 9* ST. *9* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Anna Adams*(Residence in Baltimore: No. *St Josephs Hospital* St; *10* yrs., mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Widowed*

6-DATE OF BIRTH,

Oct 6, 1850
(Month) (Day) (Year)

7-AGE,

64 yrs. *10* mos. *25* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Homemaker*9-BIRTHPLACE,
(State or Country),*Germany*

PARENTS.

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry Adams*(Address) *3009 Eastern ave*

SEP - 2 1915

Filed.....

191.

HARRY O. ANDERSON

Marital Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 1, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 22* 1915, to *Sept 1* 1915, that I saw her alive on *Sept 1* 1915, and that death occurred, on the date stated above, at *7:45* am.

The CAUSE OF DEATH* was as follows:

*Strangulated Femoral**Heart* (Duration).....yrs.....mos. *3* ds.CONTRIBUTORY
(Secondary) *Myocarditis*(Duration).....yrs.....mos. *unknown* ds.(Signed) *J. H. T. Galt* M. D......, 191... (Address) *St Josephs Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos. *10* ds. In the *6* yrs. State.....yrs.....mos. ds.Where was disease contracted, if not at place of death? *Made River*Former or usual residence *Made River Md*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oak Lawn Cem *Sept 4, 1915*

20-UNDERTAKER

ADDRESS

Mr. E. Block 927 N. Boling

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87907

C87907

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *University Hospital* ST. *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *University Hospital* St.; yrs., mo., *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

Unknown, 18*99* *Aug 29* 191*5*
(Month) (Day) (Year)

7-AGE,

16

..... yrs. mos. ds.

IF LESS than 1 day,

..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*School boy*9-BIRTHPLACE,
(State or Country),*New Jersey*

10-NAME OF FATHER,

*Francis Egan*11-BIRTHPLACE OF FATHER
(State or Country),*MD*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harold J. Tonolla*(Address) *Univ. Hospital*

15-SEP - 2 1915

NARRY O. ANDREW

Filed..... 191... *Harold J. Tonolla*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 2, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 29* 191*5*, to *Sept 2* 191*5*, that I saw him alive on *Sept 2* 191*5*, and that death occurred, on the date stated above, at *295* m.

The CAUSE OF DEATH* was as follows:

Septic pyemia

..... (Duration)..... yrs. mos. ds.

CONTRIBUTORY..... *Erysipela? Broncho*
(Secondary)

..... (Duration)..... yrs. mos. ds.

(Signed) *Harold J. Tonolla* M. D.*9/2*, 191*5*. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *5* ds. In the State *7* yrs. mos. ds.Where was disease contracted, if not at place of death? *Ellicott City Md*Former or usual residence *Ellicott City Md*

19-PLACE OF BURIAL OR REMOVAL

St Mary's Cemetery

DATE OF BURIAL,

Sept 4, 191*5*20-UNDERTAKER *Harold J. Tonolla* ADDRESS *Ellicott City**Harold J. Tonolla*

C87908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105 C87908

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1841 N. Mulberry* ST.)WARD) *20*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John Hausloof*(Residence in Baltimore: No. *1841 N. Mulberry* St.)St. *67* yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widower

16-DATE OF DEATH

Sept 1st, 1915
(Month) (Day) (Year)

6-DATE OF BIRTH

May 22, 1834
(Month) (Day) (Year)

7-AGE,

81 yrs. 3 mos. 10 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Box maker*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER

*Victor Hausloof*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Don't know*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Henry Hausloof

(Address),

1841 N. Mulberry

15-SEP - 3 1915

Filed..... 191

ROBERT . KRAUTER

Municipal Permit Officer

Registrar.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*London Park**Sept. 3, 1915*

UNDERTAKER

ADDRESS

Gen. Hubert, Room 2003 Edmunds Ave

C87909

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87909

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

CITY OF BALTIMORE: (No. 1513 Abbottston

FULL NAME Louis J. Bennett. ST.: 9

(Residence in Baltimore: No. 1513 Abbottston

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 25 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

April. 22., 1855.

7-AGE.

100 yrs. 4. mos. 21. da. If LESS than 1 day, ... hrs. or ... min. f

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Telegraph operator Hamilton Co.

9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma A. Bennett (Wife)

(Address) 1513 Abbottston St.

15-

SEP - 3 1915

ROBERT J. KRAUTER

Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

September 1., 1915.

I HEREBY CERTIFY, That I attended deceased from July 15, 1915, to Sept. 1, 1915,

that I saw him alive on August 21, 1915,

and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of the Liver and

Bronchitis (Chronic Degenerative).

CONTRIBUTORY... Exhaustion.

(Signed) J. H. Hanning, M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

London Park

DATE OF BURIAL.

Sept. 3, 1915.

ADDRESS

1460 Battery Ave.

87910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 C87910

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1002 Vine* ST.: *18* WARD)

2-FULL NAME

Elizabeth Jackson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1002 Vine*St.: *18* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female colored

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widow*

6-DATE OF BIRTH,

Unknown
(Month) (Day) (Year)

7-AGE,

60 yrs. — mos. — ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House work

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Jackson*(Address) *1002 Vine St*

15-

SEP - 3 1915

ROBERT . KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1915, to *Sept 2, 1915*,
that I saw him alive on *Sept 1st*, 1915,
and that death occurred, on the date stated above, at *9:00 am*.

The CAUSE OF DEATH* was as follows

Myocardial Stearosis(Duration) *1* yrs. *4* mos. *—* ds.

CONTRIBUTORY

(Secondary)

Cardiac Dropsy
3 weeks (Duration) *—* yrs. *—* mos. *—* ds.(Signed) *Edward J. Fisher, M. D.**Sept 2, 1915* (Address) *1012 E. Monument*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cambridge Md**Sept 3, 1915*

20-UNDERTAKER

ADDRESS

*Alfred J. Freeland**114 N. Schoder*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87911

CERTIFICATE OF DEATH.

115

C87911

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1915-C North Avenue - ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1915-C North Avenue St.; 42 yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed
(Write the word.)

6-DATE OF BIRTH, October 24th, 1850.
(Month) (Day) (Year)

7-AGE, 64 yrs., 10 mos., 9 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, House wife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Preston Peters

(Address) 131 North Broadway

15-

SEP - 3 1915

ROBERT KRAUTER,

Municipal Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 2, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19th 1915, to Sept 1st 1915, that I saw her alive on Sept 1st 1915, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

gall. bladder, (Duration) yrs. mos. ds.

(Signed) Dr. Preston Peters M. D.
Sept 2nd, 1915. (Address) 131 N. Broadway.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

Sept 5th, 1915.

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Monument

C87912

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87912

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

REGISTERED No. C

FULL NAME

Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an...
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said...
(Inquest, au-topsy or inquiry.) and that said deceased came to... death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Fatal shot wound in heart.

(Duration).... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration).... yrs. mos. ds.

(Signed).... M. D.
(Coroner.)

1915. (Address)....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Wash. D. C.

Sept. 27, 1915.

20-UNDERTAKER

ADDRESS

E. M. Mitchell & Co.

1201 W. Fayette

important. See instructions on back of certificate.

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87913

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87913

1. PLACE OF DEATH

CITY OF BALTIMORE (No. *1039 Frank St*)

2. FULL NAME *John J. Taylor*

(Residence in Baltimore: No. *1039 Frank St*)

79 REGISTERED NO. C

5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Sr. *25* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *Caucasian* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married* (Write the word)

6. DATE OF BIRTH *Aug 22, 1915* (Month) (Day) (Year)

7. AGE *50* yrs. mos. ds. or min.?

8. OCCUPATION (a) Trade, profession, or particular kind of work *Shoe Maker* (b) General nature of industry, business, or establishment in which employed (or employer) *Cobbler*

9. BIRTHPLACE (State or country) *Richmond Va.*

10. NAME OF FATHER *John Taylor*

11. BIRTHPLACE OF FATHER (State or country) *Richmond Va.*

12. MAIDEN NAME OF MOTHER *Elyza J. Camp*

13. BIRTHPLACE OF MOTHER (State or country) *Va.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Anna Taylor*

(Address) *615 N. Lombard St*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 31, 1915* (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 15*, 1915, to *Aug 31*, 1915,

that I saw him alive on *Aug 30*, 1915,

and that death occurred, on the date stated above, at *10:30* a.m.

The CAUSE OF DEATH* was as follows: *Cerebral Disease*

(Duration) yrs. mos. ds.

Contributory (SECONDARY) *Heart Failure*

(Duration) yrs. mos. ds.

(Signed) *J. H. Fisher* M. D.

714 S. Sharp St (Address) 1915.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Lafayette Cemetery*

DATE OF BURIAL

Sept. 3, 1915

20. UNDERTAKER *Wm. H. Elliott*

ADDRESS

502 N. Voss Ave

15. SEP - 3 1915

ROBERT K. KRAUTER

Permit Clerk REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87914

CERTIFICATE OF DEATH.

40 C87914

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 S. Chester ST.; V WARD)

REGISTERED NO. C

FULL NAME

Residence in Baltimore: No. 7 S. Chester St.; 15 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Jan 1, 1836
(Month) (Day) (Year)

7-AGE,

79 yrs., 8 mos., ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....John Gibson(Address).....7 S. Chester St

15-

Filed

SEP - 3 1915

HARRY K. BRAUTHER

Municipal Health Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 1915, to Sept 1 1915,that I saw him alive on Sept 1 1915,and that death occurred, on the date stated above, at 12 10 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hepatic
Clinical Diagnosis
(Duration).....yrs...6 mos.....ds.CONTRIBUTORY
(Secondary)(Duration).....yrs...7 mos.....ds.(Signed).....Inspector M. D.Sept 2, 1915. (Address).....125 S. 1st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Philadelphia

20-UNDERTAKER

H. Sanders & Sons

DATE OF BURIAL

Sept. 17, 1915

ADDRESS

1710 1st St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87915

C87915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital*)

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *University Hospital*)St.; yrs., mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, *gle*
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH,

Sept.
(Month)*20th*, *1915*
(Day) (Year)

7-AGE,

1 yrs. *5* mos. *11* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*(Child)*
*Stone*9-BIRTHPLACE,
(State or Country),*Ind.*

PARENTS.

10-NAME OF FATHER,

*J. H. Tobias*11-BIRTHPLACE OF FATHER
(State or Country),*Ohio*

12-MAIDEN NAME OF MOTHER

*Maude Tobias*13-BIRTHPLACE OF MOTHER
(State or Country),*Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. H. Tobias*(Address) *Hancock Ind.*

15-

SEP - 3 1915

ROBERT

KRAUTH,

Filed

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. *3*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

9/1 1915, to *9/3* 1915that I saw him alive on *9/3* 1915,and that death occurred, on the date stated above, at *8:05 A.M.*

The CAUSE OF DEATH* was as follows:

*Cholera**(Duration) ... yrs. ... mos. ... ds.*CONTRIBUTORY
(Secondary)*(Duration) ... yrs. ... mos. ... ds.*

(Signed)

9/3, 1915. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death, yrs. mos. *3* ds. In the State yrs. mos. ds. *Life*

Where was disease contracted, if not at place of death?

Former or usual residence

Hancock - Ind.

19-PLACE OF BURIAL OR REMOVAL,

Hancock Ind.

DATE OF BURIAL,

Sept. 3, 1915

20-UNDERTAKER

E. Schloman & Son

ADDRESS

1039 Hancock

C87916

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87916

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1148 W. Lombard)

ST. 18 WARD

REGISTERED NO. C.

2-FULL NAME

Grace Lutz

(If death occurred in a hospital or institution, give its NAME instead of street and number and full out No. 18.)

(Residence in Baltimore: No. 1148 W. Lombard)

St. 35 yrs. 10 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Oct 29

1879

(Month)

(Day)

(Year)

7-AGE

35

10

2

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE (State or country)

Balt Md

10-NAME OF FATHER

John W. Swann

11-BIRTHPLACE OF FATHER (State or country)

Md.

12-MAIDEN NAME OF MOTHER

Annie Reysen

13-BIRTHPLACE OF MOTHER (State or country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles T Lutz

(Address)

1148 W. Lombard

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

9

1

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from August 31, 1915, to Sept 1, 1915, that I saw him alive on August 31, 1915, and that death occurred, on the date stated above, at 12:14 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

Contributory (SECONDARY)

Asthma

(Signed)

J. S. Brown

M. D.

2-1

1915

[Address]

1302 W. Lombard

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt Olivet Cem

DATE OF BURIAL

Sept 4

1915

20-UNDERTAKER

John T. Lutz 1204 W. Lombard

ADDRESS

TION is very important. See instructions on back of certificate.

18-

SEP - 3 1915

ROBERT . KRAUTH, Clerk

Burial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C87917
1-PLACE OF DEATHCITY OF BALTIMORE: (No. *Mercy Hospital* ST. *17* WARD)2-FULL NAME *John G. Glosier (Glasco)*(Residence in Baltimore: No. *1137 Brewer* St. *Life* yrs. *Life* mos. *Life* ds.)29 C87917
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Single*

6-DATE OF BIRTH,

Aug 20, 1904
(Month) (Day) (Year)

7-AGE,

1 yrs. 0 mos. 11 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*(b) General nature of industry, business, or establishment in which employed (or employer) *?*9-BIRTHPLACE,
(State or Country).*Med Balto.*

10-NAME OF FATHER,

*Not known*11-BIRTHPLACE OF FATHER
(State or Country).*Not known*

12-MAIDEN NAME OF MOTHER

*Ida Glosier*13-BIRTHPLACE OF MOTHER
(State or Country).*Ida (va)*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George M. H. H. H.*(Address) *Calvert St.*

15-

SEP - 3 1915

ROBERT . KRAUTER,

Filed.....

191..

M. I. A. Permit. O. L. O. R. K.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 31, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 13, 1915, to *Aug 31, 1915*,that I saw him alive on *Aug 31, 1915*and that death occurred, on the date stated above, at *11:30* m.

The CAUSE OF DEATH* was as follows:

Acute Military Tuberculosis(Duration).....yrs.....mos.....ds. *21*CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Charles D. Smith* M. D.*Aug 31, 1915* (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. *18* In the *Life* State.....yrs.....mos.....ds.Where was disease contracted, if not at place of death? *1137 Brewer St.*Former or usual residence *1137 Brewer St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel Hill *Sept 3, 1915*

20-UNDERTAKER

ADDRESS

Daniel Easton *916 Penna Ave.*

C87918 HEALTH DEPARTMENT--CITY OF BALTIMORE

41 C87918

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital, 19* St.; *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *1523 W. Pratt St.* St.; *Life* yrs. *Life* mos. *Life* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, *Widow*

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

June 17, 1838
(Month) (Day) (Year)

7-AGE,

77 2 16
yrs. mos. ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),*Md*

PARENTS.

10-NAME OF FATHER,

*Milary Elder*11-BIRTHPLACE OF FATHER
(State or Country),*Md.*

12-MAIDEN NAME OF MOTHER

*Anna Gorsuch*13-BIRTHPLACE OF MOTHER
(State or Country),*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Record man, Hosp

(Address)

Calvert St.

15-

Filed.....

1915

Chas McClain

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 2, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 24, 1915*, to *Sept 2, 1915*, that I saw her alive on *Sept 2, 1915* and that death occurred, on the date stated above, at *6:50* m.

The CAUSE OF DEATH* was as follows:

*Carcinoma of Cecum*CONTRIBUTORY
(Secondary)*Operation Sept. 1-15*
(Duration) *Don't know* mos. ds.

(Signed)

Edward Smith M. D.

Sept 2, 1915

Mercy Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the *Life* State.....yrs.....mos.....ds.Where was disease contracted, if not at place of death? *1523 W. Pratt St*Former or usual residence *1523 W. Pratt St*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Western Cemetery**Sept 4, 1915*

20-UNDERTAKER

ADDRESS

Robt Turner 1842 4 Perry

C87919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

In rear of

CITY OF BALTIMORE (No. 530 W. Hoffman street, ST. 17 WARD)

REGISTERED NO. C.

2-FULL NAME

Sallie Pinn,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 530 W. Hoffman street,

St.: yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female,

4-COLOR OR RACE,

Colored,

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single,

6-DATE OF BIRTH,

June

30th

1915.

(Month)

(Day)

(Year)

7-AGE,

0 yrs. 2 mos. 3 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None,

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Lloyd Pinn,

11-BIRTHPLACE OF FATHER

(State or Country),

Virginia,

12-MAIDEN NAME OF MOTHER

Edith Parson,

13-BIRTHPLACE OF MOTHER

(State or Country),

Virginia,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hill, grandmother,

(Address) 530 W. Hoffman street.

SEP - 3 1915

Filed..... 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 2nd, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, au-

topsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastroenteritis,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Artificially fed,

(Duration) yrs. mos. ds.

(Signed)

M. D.

(Coroner)

Sept. 3, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death.... yrs. mos. ds. State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

87920

HEALTH DEPARTMENT—CITY OF BALTIMORE

87920

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *725* *George* ST.; *17* WARD)

2-FULL NAME

(Residence in Baltimore: No. *725* *George* ST.; *6* yrs., *6* mos., *18* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

(Month) *1* (Day) *18* (Year) *1895*

7-AGE,

41 yrs., *6* mos., *18* ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Horse Trainer*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

South Carolina

10-NAME OF FATHER,

Richard P. P. P.

11-BIRTHPLACE OF FATHER (State or Country),

S.C.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

" "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Carrie P. P.*

(Address) *725 George St.*

15-

Filed *3* 1915

1915

Chas. M. Snelair

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 2, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Feb. 18* 191*5*, to *Sept. 2* 191*5*, that I saw him alive on *Sept. 1* 191*5*, and that death occurred, on the date stated above, at *6 A.* m.

The CAUSE OF DEATH* was as follows:

Chronic Venous Cardiac Disease

(Duration) *7* yrs., *6* mos., *18* ds.

CONTRIBUTORY (Secondary)

(Duration) *5* yrs., *6* mos., *18* ds.

(Signed) *J. M. S. Snelair* M. D.

Sept. 2, 191*5*. (Address) *20 E. N. Fulton St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *6* yrs., *6* mos., *18* ds. In the State *6* yrs., *6* mos., *18* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

The Plains, Loudon Co. Va.

DATE OF BURIAL,

Sept. 5, 191*5*

20-UNDERTAKER

Dec. H. Holland

ADDRESS

Robert St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87921

CERTIFICATE OF DEATH.

91 C87921
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1524 N Dallas

ST.: 8

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Wilford Morrow

(Residence in Baltimore: No. 1524 N Dallas

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Child

6-DATE OF BIRTH,

July 12th, 1914
(Month) (Day) (Year)

7-AGE,

1 yrs. 1 mos. 19 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9-BIRTHPLACE, (State or Country),

MD

PARENTS.

10-NAME OF FATHER,

Thomas Morrow

11-BIRTHPLACE OF FATHER (State or Country),

MD

12-MAIDEN NAME OF MOTHER

Martha Sales

13-BIRTHPLACE OF MOTHER (State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Morrow

(Address)

1524 N. Dallas St.

15-

Filed

SEP 3 1915

101

Chas M Swales

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 2nd, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronch

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Elyah R. Russell M. D.
(Coroner.)

Sept 2nd, 1915 (Address) 423 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paul C. C. C.

Sept 4, 1915

20-UNDERTAKER

ADDRESS

W. A. A. A.

506 E. E. E.

important. See instructions on back of certificate.

C87922

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87922

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *601 N. Charles* ST.; *11* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *601 N. Charles* St.; *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Widow

6-DATE OF BIRTH,

January 13, 1872
(Month) (Day) (Year)

7-AGE,

93 yrs. 7 mos. 23 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Lady*9-BIRTHPLACE,
(State or Country),*Baltimore Md.*

10-NAME OF FATHER,

Riveray Johnson

11-BIRTHPLACE OF FATHER

(State or Country), *Baltimore*

12-MAIDEN NAME OF MOTHER

Mary Mackall Bowie

13-BIRTHPLACE OF MOTHER

(State or Country), *Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Morris Brown*(Address) *601 N. Charles St.*

15-

SEP - 3 1915

Filed..... 191.....

ROBERT E. KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 12, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 29 1915 to Sept 12 1915
that I saw him alive on *Aug 31 1915*and that death occurred, on the date stated above, at *6 A.M.*

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis & Myocarditis(Duration) *some* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Heart failure*(Signed) *Chambliss* M. D.*Sept 2, 1915* (Address) *1327 N. Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Greenmount

DATE OF BURIAL,

Sept 4, 1915

20-UNDERTAKER

H. W. Jenkins

ADDRESS

1111 E. Charles

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1101 N. Gilmore* ST. *16* WARD)2-FULL NAME *John Wiegroff*(Residence in Baltimore: No. *1101 N. Gilmore* St. *33* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOW,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

January 27, 1858
(Month) (Day) (Year)

7-AGE,

57 yrs. *7* mos. *6* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Grocer**Self*

9-BIRTHPLACE,

(State or Country),

Germany

PARENTS.

10-NAME OF FATHER,

John Wiegroff

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Marie M. Wiegroff*(Address) *1101 N. Gilmore*

15-

*ROBERT J. KRAUTER,*Filed *SEP - 3 - 1915**Edith Parmit Olerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 2, 1915, to *Sept 2, 1915*,that I saw him alive on *Sept 2, 1915*,and that death occurred, on the date stated above, at *11 p.m.*

The CAUSE OF DEATH* was as follows:

*Carcinoma of Stomach**(Operation) 1 mo. prior to death**(Duration) 1 1/2 yrs. mos. ds.*

CONTRIBUTORY

(Secondary)

(Duration) 1 1/2 yrs. mos. ds.(Signed) *Arthur U. Todd* M. D.*Sept 3, 1915* (Address) *737 N. Dintona*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *7* mos. *6* ds. In the State *1* yrs. *7* mos. *6* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Romaine Cem**Sept 5, 1915*

20-UNDERTAKER

ADDRESS

*Edith Parmit Olerk**507 E. N. Ave.*

C87924

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

1007 S. Kenwood Ave

REGISTERED No. C

CITY OF BALTIMORE: (No.

ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary Strzelezyk

(Residence in Baltimore: No.

1007 S. Kenwood Ave

St. 104 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

March

3

1914

(Month)

(Day)

(Year)

7-AGE,

1 yrs. 7 mos. 30 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Martin Strzelezyk

11-BIRTHPLACE OF FATHER,

(State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Mary Iwaniec

13-BIRTHPLACE OF MOTHER

(State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Iwaniec

(Address)

1007 S. Kenwood Ave

15-

ROBERT

KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

September 2, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from August 30, 1915, to August 31, 1915, that I saw her alive on August 30, 1915, and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leon S. Horta M. D.

Sept 2, 1915 (Address) 270 S. Fair Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Stanislaus Cem

Sept 9, 1915

20-UNDERTAKER

ADDRESS

Stephen J. Halpowski

1019 S. Kenwood Ave

Filed SEP - 3 1915

1915

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87925

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No.

St.; 45 yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

without

6-DATE OF BIRTH,

Jan 12, 1839

7-AGE,

76 yrs. 7 mos. 18 da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Engineer
Gas Co.

9-BIRTHPLACE, (State or Country),

Ireland

10-NAME OF FATHER,

Henry Walsh

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Catherine Hooley

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John G. Walsh

(Address)

109 W. Ostend St.

15-

Filed

SEP - 3 1915

ROBERT J. KRAUTER,
Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 1, 1915

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1915, to Sept 1, 1915, that I saw him alive on Sept 1, 1915, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Pulmonary Edema

(Duration) ... yrs. ... mos. ... ds.

(Signed)

Jas. J. O'Connor, M. D.

Sept 2, 1915 (Address) 102 E. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery Sept. 4, 1915

20-UNDERTAKER

ADDRESS

F. A. Kause, 703 Hanover

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87926

CERTIFICATE OF DEATH.

x167 C87926

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph's Hospital* ST.: *9* WARD)2-FULL NAME *Mary Catherine Hansen*(Residence in Baltimore: No. *St. Joseph's Hosp.* St.: yrs., mos. *1* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*6-DATE OF BIRTH, *1855*

(Month)

(Day)

(Year)

7-AGE, *60*

yrs. mos. ds.

If LESS than 1 day,

... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer), *at home*9-BIRTHPLACE, (State or Country), *Ind.*10-NAME OF FATHER, *Francis Barlage*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Mary Menage*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Bernard J. Barlage*(Address) *717 S. Hanover St.*

15-SEP - 3 1915

ROBERT KRAUTER,

Filed

191

BUTLER, Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 2nd*, 1915.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*

(Inquest, au-

topsy or inquiry.) and that said deceased came to *death*

on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental Burns of 3rd degree. Clothing caught fire while burning brush.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Elijah J. Russell* M. D.

(Coroner.)

Sept. 2nd, 1915. (Address) *423 N. Frederick Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *1* ds. In the *Life* State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *22 White Ave. Hamilton*19-PLACE OF BURIAL OR REMOVAL, *Cathedral Cemetery*DATE OF BURIAL, *Sept 4, 1915*20-UNDERTAKER *F. A. Krause*ADDRESS *103 Hanover*

Important. See instructions on back of certificate.

Important. See instructions on back of certificate. Exact statement of occupation is very important.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

REGISTERED NO. C.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....

191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

(Coroner.) Sept 2nd, 1915. (Address) 423 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87928

C87928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 N. Hamburg ST.; 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Laura Anna Ball

(Residence in Baltimore: No.

627 N. Hamburg

St.; 21 WARD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Feb 26, 1861

(Month)

(Day)

(Year)

7-AGE,

54 yrs. 6 mos. 6 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House Duties

9-BIRTHPLACE,
(State or Country),

Balto. Md.

10-NAME OF FATHER,

William Miller

11-BIRTHPLACE OF FATHER
(State or Country),

Germany.

12-MAIDEN NAME OF MOTHER

Lucia Alschew

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Samuel H. Ball

(Address),

627 N. Hamburg

15-

Filed

Sept 3 5

1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 2nd, 1915.

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1915 to Sept 2 1915, that I saw her alive on Sept 1 1915, and that death occurred, on the date stated above, at 2:10 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

Sept 2, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

London Park Cem

DATE OF BURIAL,

Sept 4, 1915.

20-UNDERTAKER

Mr & Mrs John W. Tufel

ADDRESS

501 N. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87929

C87929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1921 Hollins

ST.:

20

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John T. Ramsey

(Residence in Baltimore: No.

1921 Hollins St

St.:

1 yrs., 10 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Oct

12

1913

(Month)

(Day)

(Year)

7-AGE,

1 yrs., 10 mos. 11 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

W. S. Balto Md.

10-NAME OF FATHER,

John H. Ramsey

11-BIRTHPLACE OF FATHER

(State or Country),

W. S. Md

12-MAIDEN NAME OF MOTHER

Bessie Mondshaus

13-BIRTHPLACE OF MOTHER

(State or Country),

W. S. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

John H. Ramsey

(Address).

1921 Hollins St

15-

Filed

SEP - 3 1915

ROBERT K. KRAUTER,

Special Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

3

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 2- 1915, to Sept 3 1915, that I saw him alive on Sept 2 1915, and that death occurred, on the date stated above, at 1³⁰ m.

The CAUSE OF DEATH* was as follows:

Surgical Diphtheria

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

and Intoxication

(Duration) yrs. mos. 1 ds.

(Signed)

E. O. O'Connell

M. D.

Sept 3

1915

(Address)

24 W. Fellows St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Western Cemetery

Sept 3, 1915

20-UNDERTAKER.

ADDRESS

J. P. M. H. Flynn

1422 Light St

4 P. M.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87930

CERTIFICATE OF DEATH.

113 87930

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1841 Light

ST.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Pearson

(Residence in Baltimore: No. 1841 Light

St.; 40 yrs., 2 mos. 25 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Married
WIDOWED,
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH,

June 6, 1875
(Month) (Day) (Year)

7-AGE,

40 yrs., 2 mos., 25 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Lunch Room
Proprietor9-BIRTHPLACE,
(State or Country),

Balto., Md

10-NAME OF FATHER,

Robert Pearson

11-BIRTHPLACE OF FATHER
(State or Country),

Cambridge, Md

12-MAIDEN NAME OF MOTHER

Julia Smith

13-BIRTHPLACE OF MOTHER
(State or Country),

Balto., Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Pearson, Wife

(Address) 1841 Light St

15-

Filed

SEP - 3 1915

ROBERT J. KRAUTER

Morial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 18 1915 to Sept 1 1915, that I saw him alive on Aug 31 1915 and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver
Ascites

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Sept 1, 1915 (Address) 835 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

Sept. 4, 1915

ADDRESS,

1422 Light St

20-UNDERTAKER

D. & M. G. Flynn

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87931

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87931

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *1526 Harlem Ave.*

ST. *16* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME *James H. Revere.*

(Residence in Baltimore: No. *1526 Harlem Ave.*

St. *3* yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word)

6-DATE OF BIRTH *Feb. 10, 1840*
(Month) (Day) (Year)

7-AGE *75* yrs. *6* mos. *22* ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION *U.S. Mail Clerk*
(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer) *retired.*

9-BIRTHPLACE (State or country) *New York State.*

10-NAME OF FATHER *Franklin Revere.*

11-BIRTHPLACE OF FATHER (State or country) *N. Y.*

12-MAIDEN NAME OF MOTHER *Mary E. Moore.*

13-BIRTHPLACE OF MOTHER (State or country) *N. Y.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mary Revere*

(Address) *1526 Harlem Ave.*

15-SEP - 3 1915

ROBERT KRAUTER,
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept 2, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 26, 1915*, to *Sept 2, 1915*, that I saw him alive on *Sept 2, 1915*, and that death occurred, on the date stated above, at *9* m. The CAUSE OF DEATH* was as follows:

Pulmonary Oedema.

(Duration) — yrs. *3* mos. — ds

Contributory (SECONDARY) *Atherosclerosis of Coronary Arteries*
(Duration) — yrs. — mos. — ds.

(Signed) *M. B. Baumgardner* M. D.
Sept 3, 1915 (Address) *626 N. Gilman St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arlington Natl. Cem. Va.

Sept 4, 1915

20-UNDERTAKER

ADDRESS

Wm. J. Fickner, 1401 North Penna.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87932

30 C87932

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.: *14* WARD)

REGISTERED NO. C

2-FULL NAME

Mary Dora Acton

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs., 6 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

*MARRIED,**WIDOWED,**OR DIVORCED,*

(Write the word.)

Single

6-DATE OF BIRTH,

*February**9th**1914*

(Month)

(Day)

(Year)

7-AGE,

1 yrs. 6 mos. 23 ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

Filed

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Sept**1st**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *August 22* 1915, to *August 31st* 1915, that I saw her alive on *August 31st* 1915, and that death occurred, on the date stated above, at *6.30* a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis(Duration) yrs. mos. *9* ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. P. Sullivan* M. D.*Sept. 1st* 1915. (Address) *615 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *6* mos. *23* ds. In the State *1* yrs. *6* mos. *23* ds.Where was disease contracted, if not at place of death? *St. Vincent's Inf. Asylum*Former or usual residence *St. Vincent's Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral**Sept. 3* 1915

20-UNDERTAKER

ADDRESS

Martin F. Wherry 606 Lafayette Ave

Important. See instructions on back of certificate.

C87933

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87933

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asyl.* ST.; *14* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Vincent's Inf. Asyl.* St.; *1* yrs., *1* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH,

June 27, 1914.
(Month) (Day) (Year)

7-AGE,

1 yrs., *2* mos., *5* ds.If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business,
or establishment in which
employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Maryland*10-NAME OF
FATHER,*Unknown*11-BIRTHPLACE
OF FATHER
(State or Country),*Unknown*12-MAIDEN NAME
OF MOTHER*Unknown*13-BIRTHPLACE
OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

SEP - 4 1915
Filed..... 191.....
HARRY O. ANDERSON
Serial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 15, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
August 28, 1915, to *August 31, 1915*,
that I saw him alive on *August 31, 1915*,
and that death occurred, on the date stated above, at *7:00 a. m.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration).....yrs.....mos.....*5* ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *J. P. Boulton* M. D.*Sept. 15, 1915.* (Address) *615 Columbia Ave**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *5* ds. In the State *1* yrs. *2* mos. *5* ds.Where was disease contracted,
if not at place of death? *St. Vincent's Inf. Asyl.*Former or usual residence *St. Vincent's Inf. Asyl.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Leathes Hall *Sept. 3, 1915.*

20-UNDERTAKER

ADDRESS

Martin Fahy 14 Lafayette

C87934

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87934

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807. N. Bethel ST. 8 WARD)

FULL NAME

(Residence in Baltimore: No. 1807. N. Bethel st. St.; 43 yrs., mos., da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH.

— Unknown 1872

7-AGE.

43

yrs. mos. da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Cigar Maker

9-BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

John Dunn

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary McDermott

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. James Dunn

(Address)

1807 N. Bethel st.

15-

Filed

SEP - 4 1915

191

HARRY O. ANDREWS,

Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept - 1, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from July - 23 - 1915, to Sept - 1 - 1915,

that I saw him alive on Sept - 1 - 1915, and that death occurred, on the date stated above, at 6-20 P. m.

The CAUSE OF DEATH* was as follows:

Papilloma of Bladder

(Duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary)

Edema of Lungs

(Duration) yrs. 2 mos. da.

(Signed) Chas. G. Hall M. D.

Sept 2, 1915 (Address) 1617 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Lehaedial Cemetery Sept 4, 1915

20-UNDERTAKER

ADDRESS

George J. Ruth 1735. K. Street

Important. See instructions on back of certificate.

C87935

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

211 E North Ave

ST. 1

REGISTERED NO. C

WARD) 12

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

George H Hutton

(Residence in Baltimore: No.

291 E North Ave

St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widowed

6-DATE OF BIRTH

May

10

1892

(Month)

(Day)

(Year)

7-AGE

83

3

10

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

None

Retired banana maker

9-BIRTHPLACE, (State or Country),

Va.

PARENTS.

10-NAME OF FATHER,

Geo H Hutton

11-BIRTHPLACE OF FATHER (State or Country),

Scotland

12-MAIDEN NAME OF MOTHER

Emily Stevens

13-BIRTHPLACE OF MOTHER (State or Country),

Missouri

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Hutton

(Address)

211 E North Ave

15-

Filed

SEP - 4 1915

HARRY O. ANDREWS

Bureau of Health

Registrar.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH,

Sept 2

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 26

1915

to

Sept 2

1915

that I saw him alive on

Sept 1st

1915

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 7 yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary)

(Signed) J. M. Lunge

Sept 2, 1915 (Address) 127 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt. Olivet Cemetery

DATE OF BURIAL,

Sept 4, 1915

20-UNDERTAKER

H. J. McKee & Son

ADDRESS

Knox Park

Important. See instructions on back of certificate.

C87936

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87936

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No.

Johns Hopkins Hosp

ST.

6

WARD)

2-FULL NAME

Sam Jones

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

402 N. Durham St

St.; -- yrs. -- mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Unknown, 1870

(Month)

(Day)

(Year)

7-AGE

44

yrs.

mos.

ds.

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Fertilizer Laborer

9-BIRTHPLACE
(State or country)

md

10-NAME OF FATHER

Sam Jones

11-BIRTHPLACE OF FATHER
(State or country)

md

12-MAIDEN NAME OF MOTHER

Esther Tarlton

13-BIRTHPLACE OF MOTHER
(State or country)

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Smith

(Address)

Johns Hopkins Hosp

15-

SEP - 4 1915

HARRY O. ANDERSON,

Bureau Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September 2, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

August 31, 1915, to, September 2, 1915

that I saw him alive on September 2, 1915

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

~~Perforated ulcer of small intestine~~
 Acute Peritonitis (diffuse) from
 3 Intestinal Perforations & Probably antitoxin

Contributory
(SECONDARY)

Operation

(Signed)

W. E. Hardy

Sept. 2, 1915

[Address]

Johns Hopkins Hosp

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. 3 ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death? 402 N. Durham St

Former or usual residence 402 N. Durham St

19-PLACE OF BURIAL OR REMOVAL

Salisbury Cem.

DATE OF BURIAL

Sept 4, 1915

20-UNDERTAKER

Harry A. Voderer 1200 E. Main St.

TION is very important. See instructions on back of certificate.

C87937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89
21
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 W Cross St

ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caspar Steuernagel

(Residence in Baltimore: No. 1004 W Cross St

St.; 65 yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Jan 10, 1829 (Month) (Day) (Year)

7-AGE, 86 yrs. 7 mos. 24 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Tailor (b) General nature of industry, business, or establishment in which employed (or employer), Mens

9-BIRTHPLACE, (State or Country),

Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), George Steuernagel

(Address), 1004 W Cross T

15-

Filed

SEP - 4 1915 HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 3, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1915, to Sept 3 1915, that I saw him alive on Sept 2 1915, and that death occurred, on the date stated above, at 2 A m. The CAUSE OF DEATH* was as follows:

Senile Decay

(Duration) yrs. mos. ds.

CONTRIBUTORY, Bronchitis (Secondary)

(Duration) yrs. mos. 3 ds.

(Signed), M. D.

Sept. 3, 1915. (Address), 517. Scott. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Matthews Cemetery Sept 3, 1915

20-UNDERTAKER

ADDRESS

Jas Juchens & Son 207 S. Penn

Important. See instructions on back of certificate.

C87938

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87938

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Med. Gen. Hosp. 11* REGISTERED NO. C
 CITY OF BALTIMORE: (No. *11* ST. *11* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME: *Minnie Tyler*
 (Residence in Baltimore: No. *Med Gen Hospital* St.; yrs. mos. *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *Black* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single* (Write the word.)
 6-DATE OF BIRTH. *Unknown, 1900*
 (Month) (Day) (Year)
 7-AGE, *15* If LESS than 1 day, yrs. mos. da. hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *School Girl*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Maryland.*

10-NAME OF FATHER, *Edw. Tyler*
 11-BIRTHPLACE OF FATHER (State or Country), *Maryland.*
 12-MAIDEN NAME OF MOTHER, *Martha Giles*
 13-BIRTHPLACE OF MOTHER (State or Country), *Maryland.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *Edw. Tyler*
 (Address) *Glenely Ground Co.*

15-SEP - 4 1915 HARRY O. ANDREWS
 Filed..... 191. Marial Permit Q1000 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 2nd, 1915*
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Aug 23, 1915*, to *Sept 2nd, 1915*, that I saw her alive on *Sept 2nd, 1915*, and that death occurred, on the date stated above, at *4:15 P.M.*

The CAUSE OF DEATH* was as follows:

Shock from
Intestinal Haemorrhage

(Duration) yrs. mos. da. *1*
 CONTRIBUTORY (Secondary) *Typhoid fever.*

(Duration) yrs. mos. da. *23*
 (Signed) *Frank E. Shipley, M.D.*
Sept. 2, 1915 (Address) *Med. Gen. Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. *12* da. In the State..... yrs. mos. da.

Where was disease contracted, if not at place of death? *?*

Former or usual residence *Glenely, Md.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

School House Care, Sept. 9, 1915

20-UNDERTAKER and by *Med.* ADDRESS *Easton's Sons, Elliott City.*

(87939)

HEALTH DEPARTMENT--CITY OF BALTIMORE

(87939)

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; 15 yrs. 5 mos. 23 ds.)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and add out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

March

9

1900

(Month)

(Day)

(Year)

7-AGE

15

yrs.

5 23

mos.

ds.

If LESS than

1 day,

hrs.

min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

School Girl

9-BIRTHPLACE
(State or country)

Baltimore

10-NAME OF FATHER

James F. Crotty

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Mary C. Kelly

13-BIRTHPLACE OF MOTHER
(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary C. Crotty

(Address)

1505 N. Mulberry St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept.

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY That I attended deceased from

Aug 17th, 1915

to

Sept 1st, 1915

that I saw him alive on

Sept 1st, 1915

and that death occurred, on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis

(Duration)

yrs.

mos.

14 ds.

Contributory
(SECONDARY)

Exp. pneumonia

(Duration)

yrs.

mos.

ds.

(Signed)

Sept 5th, 1915

[Address]

Wm. J. Michael M. D.
401 N. E. Street

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

In the

ds.

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Orleans

Sept 4th, 1915

20-UNDERTAKER

ADDRESS

John B. Cook

1013 N. E. St.

Filed

191

HARRY C. ANDREWS,

Marital Permit Clerk

REGISTRAR

State cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

C87940

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 N. Monroe ST.; 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1627 N. Monroe St St.; 79 yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Sept 13, 1835
(Month) (Day) (Year)

7-AGE,

79 yrs., 11 mos., 18 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Insurance Agent

9-BIRTHPLACE, (State or Country),

Md.

10-NAME OF FATHER,

Robert N. Hunt

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

William H. Hunt

13-BIRTHPLACE OF MOTHER (State or Country),

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Clara N. Hunt(Address).....1627 N. Monroe St

15-

Filed.....SEP - 4 1915 HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 1, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug 27 1915 to Sept 1 1915,that I saw him alive on Sept 1 1915,and that death occurred, on the date stated above, at 1230 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

.....

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Exhaustion

..... (Duration) yrs. mos. ds.

(Signed).....Geo. J. Young M. D.Sept 2, 1915 (Address).....7531 E. Enoch

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Louder Park

DATE OF BURIAL,

Sept 4, 1915

20-UNDERTAKER

W. Cook

ADDRESS

802 E. Enoch

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hosp* ST. *4* WARD)2-FULL NAME *Mrs Anna Schuler*(Residence in Baltimore: No. *University Hospital* St.; — yrs., — mos. *18* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX. *Female* 4-COLOR OR RACE. *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *married* (Write the word.)6-DATE OF BIRTH. *April 34*, 1875 (Month) (Day) (Year)7-AGE. *40* yrs. *4* mos. *9* ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *Jas Langeras*11-BIRTHPLACE OF FATHER (State or Country), *German*12-MAIDEN NAME OF MOTHER *unobtainable*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles Schmidt*(Address) *25 Albemarle*

15-SEP - 4 1915 HARRY O. ANDREWS,

Filed..... 191... *Marial Parmit Day* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Sept 3*, 1915 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 16* 1915, to *Sept 3* 1915, that I saw her alive on *Sept 3* 1915, and that death occurred, on the date stated above, at *10:04* a.m.

The CAUSE OF DEATH* was as follows:

Septic Broncho pneumonia (Duration) ... yrs. ... mos. *7* ds.CONTRIBUTORY (Secondary) *Gonorrhea* (Duration) ... yrs. ... mos. *20* ds.(Signed) *W. H. Anderson* M. D. *Sept 3*, 1915 (Address) *University Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. *18* ds. In the State *unknown* ds.Where was disease contracted, if not at place of death? *Alhambra an, Spain*Former or usual residence *Alhambra an, Spain*19-PLACE OF BURIAL OR REMOVAL, *Baltimore* DATE OF BURIAL, *Sept 6*, 1915.20-UNDERTAKER *Dr Cook* ADDRESS *302 White*

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1*)*Mad General Hospital* ST. *9*REGISTERED NO. C. *37*

C87942

2-FULL NAME

Melvin E. Downey

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *260 Old York Road*St. *14* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, *Single*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

*Dec**2**1890*

(Month)

(Day)

(Year)

7-AGE,

24 yrs. *9* mos. *1* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...*Clerk**office*9-BIRTHPLACE,
(State or Country),*Ma*

10-NAME OF FATHER,

*W Jackson Downey*11-BIRTHPLACE OF FATHER,
(State or Country),*Ma*

12-MAIDEN NAME OF MOTHER

*Mary Pierce*13-BIRTHPLACE OF MOTHER
(State or Country),*Ma*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry S Downey*(Address) *260 Old York Rd*

15-

Filed *SEP -4 1915*

191

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Sept**3**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 25* 1915, to *Sept 3* 1915, that I saw him alive on *Sept 3* 1915, and that death occurred, on the date stated above, at *8:30 AM*.

The CAUSE OF DEATH* was as follows:

Meningitis(Duration) ... yrs. ... mos. ... ds. *9*CONTRIBUTORY
(Secondary)*Syphilis (?) T.R. (?)*(Duration) ... yrs. ... mos. ... ds. *?*(Signed) *Frank E. Stephens* M. D.*Sept 3* 1915. (Address) *Mad. Genl. Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. *9* ds. *14* yrs. *9* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *260 Old York Road*

19-PLACE OF BURIAL OR REMOVAL,

Loudon Park

20-DATE OF BURIAL,

Sep 7 1915

21-UNDERTAKER

Wm Cook

ADDRESS

502 E North Ave

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Laurens ST.; 15 WARD)2-FULL NAME Charles E. Powell

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1414 Laurens St.; 31 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

January, 1883
(Month) (Day) (Year)

7-AGE

32 yrs., mos., da.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Pharmacist
Cobbler9-BIRTHPLACE,
(State or Country).Frederick Ind

10-NAME OF FATHER,

Thomas Powell11-BIRTHPLACE OF FATHER
(State or Country).Ind

12-MAIDEN NAME OF MOTHER

Johna Grummell13-BIRTHPLACE OF MOTHER
(State or Country).Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Powell(Address) 1414 Laurens St.

15-

SEP - 4 1915

Filed

ROBERT KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept, 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 14, 1914, to Sept 2, 1915,
that I saw him alive on Sept 2, 1915,and that death occurred, on the date stated above, at 5.9 m.

The CAUSE OF DEATH* was as follows:

Sclerosis
(Duration) 1 yrs., mos., da.CONTRIBUTORY
(Secondary)Valvular Heart Disease
(Duration) 1 yrs., mos., da.
(Signed) Thomas Nelson, M. D.
Sept 3, 1915 (Address) 1403 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

Sept. 4, 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E North
Co

Important. See instructions on back of certificate.

THIS CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCASION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* St. *7* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Albert Corpening*
(Residence in Baltimore: No. *Johns Hopkins Hosp* St. *7* yrs. *8* mos. *8* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *white* 5-SINGLE MARRIED *married* WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH *February 8, 1852* (Month) (Day) (Year)
7-AGE *63* yrs. *6* mos. *26* ds. or min. *1* day, *hrs.*
8-OCCUPATION (a) Trade, profession or particular kind of work *Farmer* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

N.C.

PARENTS

10-NAME OF FATHER *Albert C. Corpening*
11-BIRTHPLACE OF FATHER (State or country) *N.C.*
12-MAIDEN NAME OF MOTHER *Ephie Harshaw*
13-BIRTHPLACE OF MOTHER (State or country) *N.C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. J. Smith*
(Address) *Johns Hopkins Hospital*

15-

SEP - 4 1915

ROBERT KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *September 3, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *August 27, 1915*, to, *September 3, 1915*, that I saw him alive on *September 3, 1915*, and that death occurred, on the date stated above, at *10:25 a.m.*
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (Left)
two days (Duration) *2* yrs. *5* mos. *15* ds.

Contributory (SECONDARY) *Opportunistic Pneumonia* (Duration) *5* yrs. *5* mos. *15* ds.
(Signed) *Dr. McBurket* M. D.
Sept 3, 1915 [Address] *Johns Hopkins Hosp.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *8* yrs. *8* mos. *8* ds. In the *8* yrs. *8* mos. *8* ds. State *8* yrs. *8* mos. *8* ds.
Where was disease contracted, If not at place of death?
Former or usual residence *Hawlett St.*

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Granite Falls N.C. *Sept 4, 1915*

20-UNDERTAKER ADDRESS

Albert C. Fuller *221 N. Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

087945

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

087945

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

1520 Thames

ST.

3

WARD)

REGISTERED No. C

2-FULL NAME

Wladislaw Niewiadomski (Niewiadomski)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1520 Thames

St.; yrs., 1 mon. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

June

27

1914

(Month)

(Day)

(Year)

7-AGE,

1 yrs. 2 mos. 6 ds.

IF LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Jas Niewiadomski

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Francesca Kotowski

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jas Niewiadomski

(Address)

1520 Thames St.

15-

SEP - 4 1915

ROBERT . KRAUTH

Filed

191

Sur. Gen. Permit. Officer

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September

3rd

1915.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. W. Jones

M. D.

(Coroner)

Sept 3, 1915

(Address) 1516 Osmond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

10-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary Am

Sept 4, 1915

20-UNDERTAKER

ADDRESS

Jacob Zalkowski

428 S Bond St

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87946

CERTIFICATE OF DEATH

151 C87946

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 520 S. Curley St. ST. 1 WARD)

2-FULL NAME

William S. McWilliams

(Residence in Baltimore: No. 520 S. Curley St. St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Sept. 2, 1915

7-AGE

If LESS than

1 day, hrs.

yrs. mos. 1 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Baltimore City.

10-NAME OF FATHER

John McWilliams

11-BIRTHPLACE OF FATHER (State or country)

Md.

12-MAIDEN NAME OF MOTHER

Catharine Glover

13-BIRTHPLACE OF MOTHER (State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Catharine McWilliams

(Address)

520 S. Curley St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept. 3rd, 1915

17- I HEREBY CERTIFY, That I attended deceased from

Sept 2nd, 1915, to Sept 3rd, 1915,

that I saw him alive on Sept 3rd, 1915,

and that death occurred, on the date stated above, at 6⁰⁰ m.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) yrs. mos. 1 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Adam A. God

M. D.

Sept 3rd, 1915 [Address] 439 S. Eglar St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Not Camel Cem.

DATE OF BURIAL

Sept 21, 1915

20-UNDERTAKER

Lilly & Co. J. E. J. E.

ADDRESS

403 S. W. 10th St.

SEP - 4 1915

ROBERT J. KRAUTER,

Chief Permit Officer

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE, (No.

FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME, instead of street and number and fill out No. 18.)

St.; yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word)

Single

6-DATE OF BIRTH.

Baltimore Nov. 1, 1914

7-AGE,

X

10

yrs.

mon.

ds.

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

SEP - 4 1915

191

ROBERT A. KRAUTH

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

September 2, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 1 1915, to Sept 2 1915

that I saw him alive on Sept 2 1915

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Rochitis superinduced by gastric enteritis.

(Duration) yrs. mon. ds.

CONTRIBUTORY (Secondary) gastric enteritis

(Duration) yrs. mon. ds.

(Signed) J. Guy Bruley M. D.

9/3/15 (Address) 1136 W. 14th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Mt Auburn Ct

DATE OF BURIAL.

Sept. 4, 1915

20-UNDERTAKER

J. L. Brown & Son 108 W. Myrtle

ADDRESS

Franklin D. Roosevelt

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *17* ST. *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *592 Greenwillow St* St.: _____ yrs. _____ mos. _____ da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

..... *Unknown* ; *1*
(Month) (Day) (Year)

7-AGE.

22 yrs. mos. da.If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Laundress*
General

9-BIRTHPLACE, (State or Country),

Maryland

PARENTS.

10-NAME OF FATHER,

Do not know

11-BIRTHPLACE OF FATHER (State or Country),

Do not know

12-MAIDEN NAME OF MOTHER

Do not know

13-BIRTHPLACE OF MOTHER (State or Country),

Do not know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *J. P. L. Wright*
(Address)..... *Md. Genl. Hospital*

15-

SEP - 4 1915

191

ROBERT K. BRAUTON
Burial Permit Officer
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

..... *September* *1* , 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
March 29 191*5*, to *Sept. 1* 191*5*,
that I saw her alive on *Sept. 1* 191*5*,
and that death occurred, on the date stated above, at *11:20 am*.

The CAUSE OF DEATH* was as follows:

..... *Cardiac Deilitation*
..... (Duration) ? yrs. ? mos. ? da.

CONTRIBUTORY (Secondary)

..... *Chronic Nephritis*
..... (Duration) ? yrs. 5 mos. ? da.(Signed)..... *Frank E. Shipley* M. D.
..... *Sept. 1* , 191*5* (Address) *Md. Genl. Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. *5* mos. da. In the State..... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence *592 Greenwillow St.*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

..... *Laurel Cemetery* *Sept. 4* , 191*5*
..... UNDERTAKER ADDRESS *James H. Dennis* *1302 Preston*

important. See instructions on back of certificate.

See Birth certificate of
Mieczystaw Diekleski, Born Aug. 7th. 1915
See Birth Certificate No. B-17299

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE; (No.

2-FULL NAME.

(Residence in Baltimore: No.

ST. 1 WARD)

REGISTERED NO. C

(If death occurred in a
hospital or institution,
give its NAME instead
of street and number and
fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

single

6-DATE OF BIRTH,

Aug 7, 1915
(Month) (Day) (Year)

7-AGE,

23
yrs. mos. ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....

none

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF
FATHER,

Szymon Duklewski

11-BIRTHPLACE
OF FATHER
(State or Country),

Russia

12-MAIDEN NAME
OF MOTHER

Maryana Sadzinska

13-BIRTHPLACE
OF MOTHER
(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Szymon Duklewski

(Address) 3040 Boston St

15-

Filed

SEP 4 1915

191

Ellen Clark

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 3, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from
Sept 2 1915, to Sept 3 1915,
that I saw her alive on Sept 2 1915

and that death occurred, on the date stated above, at 12:20

The CAUSE OF DEATH* was as follows:

Acute Enterocolitis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Horace Titlow M. D.

Sept 3, 1915 (Address) 3035 Odumwell St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
IENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

St Stanislaus Bern

DATE OF BURIAL,

Sept 5, 1915

20-UNDERTAKER

Stephen J. Tiakowski

ADDRESS

1019 S. Fenwick St

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

087951
PLACE OF DEATH Johns Hopkins Hospital
CITY OF BALTIMORE: (No. 1 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)
2-FULL NAME Pearl Hecht
(Residence in Baltimore: No. 617 Rose St. St.; unknown yrs. unknown mos. unknown ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX <u>Female</u>	4-COLOR OR RACE <u>White</u>	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
6-DATE OF BIRTH <u>July 3</u> 19 <u>15</u> (Month) (Day) (Year)		
7-AGE <u>8 weeks</u> If LESS than 1 day, <u>hrs.</u> <u>min.</u> yrs. mos. ds. or min.?		
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>		
9-BIRTHPLACE (State or country) <u>med.</u>		
PARENTS	10-NAME OF FATHER <u>unknown</u>	
	11-BIRTHPLACE OF FATHER (State or country) <u>unknown</u>	
	12-MAIDEN NAME OF MOTHER <u>unknown</u>	
	13-BIRTHPLACE OF MOTHER (State or country) <u>unknown</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

P. P. Phelps
Johns Hopkins

15-

Filed

191

Blumelaci
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
Sept. 3 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 3 1915 to Sept. 3 1915, that I saw her alive on Sept. 3 1915, and that death occurred, on the date stated above, at 8:30 p.m.
The CAUSE OF DEATH* was as follows:
Gangrene (Nona) of Back.

(Duration) unknown yrs. unknown mos. unknown ds.

Contributory (SECONDARY)
None
(Duration) unknown yrs. unknown mos. unknown ds.

(Signed), A. F. Powers, M. D.
Sept. 4 1915 [Address] Johns Hopkins Hosp.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death? ✓

Former or usual residence 617 Rose St.

19-PLACE OF BURIAL OR REMOVAL
St. Stanislaus DATE OF BURIAL
Sept 5 1915

20-UNDERTAKER
M. F. Sadowski ADDRESS
705 S. Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *504 Myrtle Ave* ST. *17* WARD)

2-FULL NAME

(Residence in Baltimore: No. *504 Myrtle Ave* St. *17* yrs. *1* mos. *1* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *Col.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH. *1888*
(Month) (Day) (Year)7-AGE. *77* yrs. *1* mos. *1* ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Retired preacher*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Balt. Md.*10-NAME OF FATHER, *Lydia Goldsborough*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER *Mary S. Williams*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. E. Goldsborough*(Address) *504 Myrtle Ave*15- *ROBERT E. KRAUTH*Filed *SEP - 4 1915* *191*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 2*, 191*5*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan. 2* 191*4*, to *Sept. 2* 191*5*, that I saw him alive on *Sept. 1* 191*5*, and that death occurred, on the date stated above, at *5:40* m. The CAUSE OF DEATH* was as follows:*Cerebral Hemorrhage*
(Duration) *4* yrs. *5* mos. *5* ds.CONTRIBUTORY (Secondary) *Arteriosclerosis*
(Duration) *2* yrs. *1* mos. *1* ds.(Signed) *Wm. E. Goldsborough* M. D.
Sept. 3 191*5* (Address) *204 N. Fulton Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. *Laurel Cemetery* DATE OF BURIAL. *Sept. 5*, 191*5*20-UNDERTAKER *Geo. H. Holland* ADDRESS *517 Robert St.*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1007 Bush* ST.; *21* WARD)2-FULL NAME *James Bush (Boss)*(Residence in Baltimore: No. *1007 Bush* St.; yrs. *11* mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH

Oct. 2, 191*5*

(Month)

(Day)

(Year)

7-AGE,

11 yrs. *11* mos. *11* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

James Bush

11-BIRTHPLACE OF FATHER (State or Country),

D.C.

12-MAIDEN NAME OF MOTHER

Maggie McLaughlin

13-BIRTHPLACE OF MOTHER (State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

James Bush
1007 Bush St.

15-

ROBERT . KRAUTER,

SEP - 4 1915

MURIEL PERMIT OLIVER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 2, 191*5*

(Month)

(Day)

191*5* (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 1, 191*5*, to *Sept 2*, 191*5*,that I saw him alive on *Sept. 2*, 191*5*,and that death occurred, on the date stated above, at: *8 P. m.*

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Mal. Nutrition

(Duration) yrs. mos. ds.

(Signed)

Shepherd Drain M. D.*Sept 3*, 191*5*. (Address) *1227 Columbia*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Peter's Church**Sept. 4*, 191*5*.

20-UNDERTAKER

ADDRESS

John J. Cairns, *901 Hollings*

important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87954

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87954

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135

St. 1 Pappleton

WARD 48

2-FULL NAME

Patrick Quinn

(Residence in Baltimore: No. 1250

Pappleton

St. 79

ysr. mos. ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Michael

6-DATE OF BIRTH

unknown

(Month)

(Day)

1836

7-AGE

74

ysr.

mos.

ds.

1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Street Car

9-BIRTHPLACE

(State or country)

County Limerick, Ireland

10-NAME OF FATHER

Patrick Quinn

11-BIRTHPLACE OF FATHER

(State or country)

County Limerick

12-MAIDEN NAME OF MOTHER

Bridgman

13-BIRTHPLACE OF MOTHER

(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

1250 Pappleton

15-

Filed

SEP - 4 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sep 2

(Month)

(Day)

1915

17-I HEREBY CERTIFY, That I attended deceased from

Jan 7, 1915, to, Sep 2, 1915,

that I saw him alive on, Sep 2, 1915,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Clinical Diagnosis
Carcinoma of Penis

Contributory (SECONDARY)

(Signed)

Harry Boyd

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....ysr.....mos.....ds. In the State.....ysr.....mos.....ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Peter's Cemetery

Sept 6, 1915

20-UNDERTAKER

ADDRESS

George J. Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 S. Milton Ave. ST. 1 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian B. Schreiner(Residence in Baltimore: No. 504 S. Milton St. 1 yrs. 5 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

single

6-DATE OF BIRTH,

Aug311915

(Month)

(Day)

(Year)

7-AGE,

If LESS than 1 day,

yrs. 5 mos. 5 ds.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Balt. City

PARENTS.

10-NAME OF FATHER,

George L. Schreiner

11-BIRTHPLACE OF FATHER

(State or Country),

Balt. City

12-MAIDEN NAME OF MOTHER

Annie E. Miller

13-BIRTHPLACE OF MOTHER

(State or Country),

Balt. City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George L. Schreiner(Address) 504 S. Milton

15-

Filed

191

Chas. M. Sueland

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept41915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 3 1915, to Sept 3 1915,that I saw her alive on Sept 3 1915,and that death occurred, on the date stated above, at 6⁰⁰ a.m.

The CAUSE OF DEATH* was as follows:

Congenital debility(Duration) 5 yrs. 5 mos. 5 ds.

CONTRIBUTORY

(Secondary)

Exhaustion(Duration) 1 yr. 1 mos. 1 ds.

(Signed)

C. L. Fine

M. D.

9/4, 1915. (Address) 2701 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 5 yrs. 5 mos. 5 ds. In the State 5 yrs. 5 mos. 5 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. PatrickSept 5, 1915

20-UNDERTAKER

ADDRESS

John A. HowardBank

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 C87956

CERTIFICATE OF DEATH.

PLACE OF DEATH
 CITY OF BALTIMORE: (No. *13 S. Carey*) ST.: *18* WARD) REGISTERED NO. C.....
 FULL NAME *Ludwig Himefeld* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 (Residence in Baltimore: No. *13 S. Carey* St.: *34* yrs., *✓* mos. *✓* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)
 6-DATE OF BIRTH, *Oct 3, 1840*
 (Month) (Day) (Year)
 7-AGE, *75* yrs., *11* mos., *✓* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work..... *Retired Ins. Agt.*
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *Unknown*
 11-BIRTHPLACE OF FATHER (State or Country), *Germany*
 12-MAIDEN NAME OF MOTHER, *Unknown*
 13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *Henry L. Himefeld*
 (Address) *2019 W. Pratt St.*

15-SEP - 4 1915 *Chas. M. Suclaw*
 Filed 191. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 3, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 10, 1915* to *Sept 3, 1915*, that I saw him alive on *Sept 2nd, 1915*, and that death occurred, on the date stated above, at *1:30 P. m.*

The CAUSE OF DEATH* was as follows:

Senile Arterio Sclerosis

(Duration) *Under 5 mos.*
 CONTRIBUTORY *Cerebral Hemorrhage*
 (Secondary)

(Signed) *Henry L. Himefeld* M. D.
Sept 3, 1915 (Address) *1203 W. Fayette St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park* DATE OF BURIAL, *Sept 5, 1915*

20-UNDERTAKER, *Sec. L. Schwab & Bro.* ADDRESS *219 Thacker Ave.*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87957

C87957

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Howard A. Kelly Hosp. Inc*
 CITY OF BALTIMORE: (No. *1418 Eutaw Place* ST., *12* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Miss Martha A. Clark*

(Residence in Baltimore: No. *2504 N. Charles* St.; *5* yrs., *5* mos., *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *Single*
 MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
 6-DATE OF BIRTH, *March 18, 1877*
 (Month) (Day) (Year)

7-AGE, *38* yrs., *5* mos., *5* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Experienced*
 (b) General nature of industry, business, or establishment in which employed (or employer). *Nurse*

9-BIRTHPLACE, (State or Country), *Maryland*
Harford County

10-NAME OF FATHER, *Mr William T. Clark*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*
Harford Co.

12-MAIDEN NAME OF MOTHER *Miss Margaret Ady*

13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*
Harford Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Samuel Witts*

(Address) *917 Harlem Ave*

15-SEP 4 1915 *Ed Mairlan*

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 3*, *3*, *1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 22* 191*4*, to *Sept 3* 191*5*, that I saw her alive on *Sept 3* 191*5*, and that death occurred, on the date stated above, at *1-30 P.M.*

The CAUSE OF DEATH* was as follows:
Cerebral & pulmonary metastasis
following operation for cancer of breast.
 (Duration) *1* yrs., *2* mos., *17* ds.

CONTRIBUTORY (Secondary) (Duration).....yrs.....mos.....ds.

(Signed) *Robert M. Lewis* M. D.
Sept 3, 191*5*. (Address) *1418 Eutaw Pl., Balt.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the *life* State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? *2504 N. Charles*

Former or usual residence *2504 N. Charles St.*

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL, *Sept 5*, 191*5*

Rock Spring Cemetery

20-UNDERTAKER *Chas. G. Block* ADDRESS *1201 N. Muller St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.

C87958

C87958

REGISTERED NO. C 737

PLACE OF DEATH

CITY OF BALTIMORE (No. 1036 Valley

2-FULL NAME Charles Henry Hughes

St.: 10 WARD)

(Residence in Baltimore: No. 1036 Valley

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Infant
6-DATE OF BIRTH, Aug 8th, 1915
7-AGE, 27 yrs. 27 mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE, (State or Country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or Country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary Cunningham
(Address) 1036 Valley St.

15 SEP 4 1915
Filed, Chas. W. Mueller Registrar.

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH, Sept 4th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry, thereon and from the evidence obtained by said Inquest, autopsy or inquiry, And that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Icterus Neonatorum

CONTRIBUTORY (Secondary)

(Signed) Elyah J. Russell, M. D.
(Coroner.)
1915 (Address) 423 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL

Holy Cross Cem. DATE OF BURIAL, Sept 4, 1915

20-UNDERTAKER

H.C. Wiedefeld 914 Summit Ave ADDRESS

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *1634 Ashland Ave* ST. *7* WARD)

2-FULL NAME *Virginia R Johnson*

(Residence in Baltimore: No. *1634 Ashland Ave* St. *76* yrs. *0* mos. *29* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Aug 6* 1899
(Month) (Day) (Year)

7-AGE *76* yrs. *0* mos. *29* ds. or *1* day, *0* hrs., *0* min.?
If LESS than 1 day, hrs., min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *dom*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Balt City*

10-NAME OF FATHER *Ezekiel C. Johnson*

11-BIRTHPLACE OF FATHER (State or country) *md*

12-MAIDEN NAME OF MOTHER *Susan R Fry*

13-BIRTHPLACE OF MOTHER (State or country) *Pa*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harry C. Johnson*

(Address) *1634 Ashland Ave*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept 4* 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 7*, 1915, to, *Sept 4*, 1915, that I saw her alive on *Sept 1*, 1915, and that death occurred, on the date stated above, at *8:40* m. The CAUSE OF DEATH* was as follows:

apoplexy, Paralysis
Cereb

(Duration) yrs. mos. ds. *28*
Contributory (SECONDARY) *General Paralysis*

(Signed) *Chas B. Fisher* M. D.
Sept 4, 1915. [Address] *838 E Broadway*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Balt City *Sept 7* 1915

20-UNDERTAKER ADDRESS

Robt Janner *1424 Bimby*

SEP - 5 1915

ROBERT J. ZRAUTER
REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

878960

HEALTH DEPARTMENT—CITY OF BALTIMORE

155
887960

CERTIFICATE OF DEATH.

PLACE OF DEATH Hahnemann General Hospital,
CITY OF BALTIMORE (No. 1122 N. Mount street, ST. 16 WARD)
FULL NAME Elias Mummert,
(Residence in Baltimore: No. 2757 Rayner Avenue, St.; yrs., 2 mos. ds.)

REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, Married,
WIDOWED, OR DIVORCED. (Write the word.)
6-DATE OF BIRTH, December 22nd, 1868.
(Month) (Day) (Year)
7-AGE, 46 yrs., 8 mos., 13 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House carpenter,
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Pennsylvania,

PARENTS.
10-NAME OF FATHER, ? Mummert,
11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania,
12-MAIDEN NAME OF MOTHER, Unknown,
13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Katharine Mummert, wife,
(Address) 2757 Rayner avenue.

15- ROBERT KRAUTER, Registrar.
Burial Permit Clerk
SEP - 5 1915

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 4th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Carbolic acid poisoning,
((suicide)).
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. Frederick Kumpke, M. D. (Coroner.)
Sept. 4, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place 1/2 hour, In the 2 yrs. 2 mos. 2 ds.
of death yrs. mos. ds. State? yrs. mos. ds.
Where was disease contracted, if not at place of death? 2757 Rayner avenue,
Former or usual residence 2757 Rayner avenue.

19-PLACE OF BURIAL OR REMOVAL, HANOVER TOWN, DATE OF BURIAL, Sept 6 1915.

20-UNDERTAKER, William Cooks, ADDRESS 502 S North Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1110 Orleans* ST.; *5* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1110 Orleans* St.; *49* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE.

*White*1-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

July 28, 18*66*
(Month) (Day) (Year)

7-AGE.

49 yrs., *1* mos., *4* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Bank*
*Money*9-BIRTHPLACE,
(State or Country),*Balto*

10-NAME OF FATHER,

*Mr E Stein*11-BIRTHPLACE OF FATHER
(State or Country)*Germany*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

My J & Stein
1110 Orleans St

15-

SEP - 5 1915

ROBERT KRAUTER,

Filed..... 191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 2, 191*4*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 14, 191*5*, to *Sept 2*, 191*5*,that I saw him alive on *Sept 2*, 191*5*,and that death occurred, on the date stated above, at *8:30 P. m.*

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease(Duration) *2* yrs., mos., ds.CONTRIBUTORY
(Secondary)

(Duration) yrs., mos., ds.

(Signed) *Robert Krauter* M. D.*Sept 4*, 191*5*. (Address) *120 1/2 Disgrace St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Balto County**Sept 5*, 191*5*.

20-UNDERTAKER

ADDRESS

Robert Krauter 4221 Bwa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St Joseph Hospital* 5 WARD
CITY OF BALTIMORE (No. *St Joseph Hospital* ST.: *5*)
2-FULL NAME *Annal Levy*
(Residence in Baltimore: No. *Hebrew Aged Womens Home* St.: *18* yrs., *1* mos., *2* ds.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow*
(Write the word.)
6-DATE OF BIRTH, *Unknown*, *1853*
(Month) (Day) (Year)
7-AGE, *62* yrs., *1* mos., *2* ds.
If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....
9-BIRTHPLACE, (State or Country), *Austria*
10-NAME OF FATHER, *Unknown*
11-BIRTHPLACE OF FATHER (State or Country), *Unknown*
12-MAIDEN NAME OF MOTHER, *Unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Levy*
(Address) *115 N. Hollins St.*

15-SEP - 5 1915
Filed *101* *ROBERT KRAUTER*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 3rd*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*,
(Inquest, autopsy or inquiry.)
And that said deceased came to *his* death
on the day stated above.

The CAUSE OF DEATH* was as follows:

(Suicide) jumped from 2nd story window
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Elijah J. Russell* M. D.
(Coroner.)
Sept 3rd, *1915* (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Hebrew Aged Womens Home*

19-PLACE OF BURIAL OR REMOVAL, *Hebrew Rosedale*

DATE OF BURIAL, *9/5*, *1915*

20-UNDERTAKER, *Joek Lewis*

ADDRESS *744 E. Baltimore St.*

C87963 HEALTH DEPARTMENT—CITY OF BALTIMORE C87963

CERTIFICATE OF DEATH.

28
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 451 Orchard - ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

James Williams

(Residence in Baltimore: No. 451 Orchard - St. 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE

Col.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH

Unknown, 1
(Month) (Day) (Year)

7-AGE

27 yrs. mos. ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer
General

9-BIRTHPLACE

(State or Country)

Maryland

10-NAME OF FATHER

Bishop Williams

11-BIRTHPLACE OF FATHER

(State or Country)

Md

12-MAIDEN NAME OF MOTHER

Benjie Steward

13-BIRTHPLACE OF MOTHER

(State or Country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Benjie Steward

(Address) 451 Orchard St

15-

File SEP - 5 - 1915

ROBERT KRAUTER

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 31, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 2 1915 to Sept 3 1915, that I saw him alive on Sept 2 - 1915, and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Consumption
(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

Exhaustion (Duration) yrs. 4 mos. ds.
(Signed) Samuel A. Davis M. D.
Sept 3, 1915. (Address) 937 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt Auburn Cemetery

DATE OF BURIAL

Sept 5, 1915

20-UNDERTAKER

Charles B. Jones

ADDRESS

1112 N. Santa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87964 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87964

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 4 WARD)

REGISTERED NO. C

2 FULL NAME

(Residence in Baltimore: No.

St. 3 2 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 SEP - 5 1915

Filed, 191

ROBERT KRAUTH
Burial Permit Officer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2nd, 1915, to Sept 3rd, 1915, that I saw him alive on Sept 3, 1915, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows:

Chronic Pulmonary disease (cardiac)

Contributory (SECONDARY)

(Signed) Harry Glassman M. D.
Sept 3, 1915 (Address) 742 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

C87965

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87965

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Med Gen Hospit. 14* REGISTERED NO. C _____
 CITY OF BALTIMORE: (No. *14* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME *William J. Whicks*
 (Residence in Baltimore: No. *201 Smith Court* St.: *14th* yrs. *1* mos. *1* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *Black* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
 6-DATE OF BIRTH, *?* (Month) *1* (Day) (Year)
 7-AGE, *44* yrs. *?* mos. *?* da. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Driver*
 (b) General nature of industry, business, or establishment in which employed (or employer). *unknown*

9-BIRTHPLACE, (State or Country). *Balt. Maryland*

10-NAME OF FATHER, *Mr. Whicks*
 11-BIRTHPLACE OF FATHER (State or Country). *Id*
 12-MAIDEN NAME OF MOTHER *Annie Johnson*
 13-BIRTHPLACE OF MOTHER (State or Country). *Id*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. L. Wright*
 (Address) *Med Gen Hosp*

15- *SEP - 5 1915* ROBERT KRAUTER
 Filed *1915* Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 31st*, 1915.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 25th* 1915, to *Aug 31st* 1915, that I saw him alive on *Aug 31st* 1915, and that death occurred, on the date stated above, at *2 P* m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(Duration) *1* yrs. *1* mos. *1* da.
 CONTRIBUTORY (Secondary) *Typhoid fever*

(Duration) *16 weeks*
 (Signed) *Frank E. Shipley* M. D.
Aug. 31st, 1915. (Address) *Med Gen Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *7* mos. *7* da. In the State *1* yrs. *1* mos. *1* da.

Where was disease contracted, if not at place of death? *?*

Former or usual residence *201 Smith Court*

19-PLACE OF BURIAL OR REMOVAL,

St. Luke's Cemetery

DATE OF BURIAL,

Sept 5th, 1915.

20-UNDERTAKER

J. B. Jones

ADDRESS

1119 Barclay St

Caution of Death in plain form so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

at morgue

Sept 1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87966

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87966

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *1227 N Dallas* ST. *8* WARD)

2 FULL NAME

Wm E. Walker

(Residence in Baltimore: No. *1227 N Dallas* St. *8* yrs. *4* mos. *4* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

Married

6 DATE OF BIRTH

Feb

13th

1870

7 AGE

45

7

mos.

17

ds.

or

min.

hrs.

If LESS than

1 day,

hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Hod carrier

9 BIRTHPLACE
(State or country)

Balto. Md.

10 NAME OF FATHER

Emory Walker

11 BIRTHPLACE OF FATHER
(State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Elizabeth Smith

13 BIRTHPLACE OF MOTHER
(State or country)

Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary A. Walker

(Address)

1227 N. Dallas St.

SEP - 5 1915

Filed

191

ROBERT E. BRAUTER
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept

2

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May, 1915, to *Sept 2*, 1915.

that I saw him alive on *Aug 31*, 1915.

and that death occurred, on the date stated above, at *1259* m.

The CAUSE OF DEATH* was as follows:

Cerebral Paralysis

(Duration)

yrs.

4

mos.

4

ds.

Contributory
(SECONDARY)

Coma

(Duration)

yrs.

1

mos.

4

ds.

(Signed)

J. H.

1915

(Address)

2094 Broadway

M. D.

Dr. S. Sage

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

19 PLACE OF BURIAL OR REMOVAL

Shark St. Cem. Chase St.

DATE OF BURIAL

Sept 5-1915

20 UNDERTAKER

Harry A. Voderberg

ADDRESS

1725 Orleans St.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87967

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1706 Baker street,
2-FULL NAME Rodney W. Carroll,
(Residence in Baltimore: No. 1706 Baker street,

ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, Married, (Write the word.)
6-DATE OF BIRTH, December 18th, 1876. (Month) (Day) (Year)
7-AGE, 38 yrs., 8 mos., 15 ds. If LESS than 1 day, ...hrs. or ...min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Public waiter. (b) General nature of industry, business, or establishment in which employed (or employer), Restaurant.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.
10-NAME OF FATHER, Henry Carroll,
11-BIRTHPLACE OF FATHER, (State or Country), Maryland,
12-MAIDEN NAME OF MOTHER, Sarah Ockerme,
13-BIRTHPLACE OF MOTHER, (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...Belle Carroll, wife,
(Address)...1706 Baker street

15- SEP - 5 1915 ROBERT KRAUTH, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 2nd, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows:

Mitral regurgitation,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Kumpel, M. D. (Coroner.)

Sept. 3, 1915. (Address) 3310 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Jos. A. Jodson

142 W. Hill St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87968

CERTIFICATE OF DEATH.

all Hankins
Charles F. Randall

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 N. Sturke ST.; 16 WARD)

FULL NAME Ella Margaret Jessop

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1009 N. Sturke St.; 0 yrs, 3 mos. 27 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
6-DATE OF BIRTH, May 8th, 1915
(Month) (Day) (Year)

7-AGE, 0 yrs, 3 mos, 27 ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), City Balto

10-NAME OF FATHER, James M. Jessop Jr

11-BIRTHPLACE OF FATHER, (State or Country), City Balto

12-MAIDEN NAME OF MOTHER, Rose Joyce

13-BIRTHPLACE OF MOTHER, (State or Country), City Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James M. Jessop Jr
(Address) 1009 N. Sturke St.

15-SEP - 5 1915
Filed 1915

ROBERT K. KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep 6 4th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 12 1915, to Sept 4th 1915, that I saw her alive on Sept 3rd 1915, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Cholera Infantum

(Duration) yrs. mos. 23 ds.

(Signed) J. F. Hankins M. D.
1885 (Address) 18 Randall St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

My Office Sep 5th, 1915.

20-UNDERTAKER

ADDRESS

Mr. Weber & Son 2503 Schumacher Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1817 Laureates* ST.;

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Modislous G. Gabor*(Residence in Baltimore: No. *1817 Laureates* St.;

yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)6-DATE OF BIRTH, *March 11, 1914*

(Month)

(Day)

(Year)

7-AGE, *1 yrs. 5 mos. 18 ds.*

If LESS than 1 day.

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Modislous Gabor*11-BIRTHPLACE OF FATHER, (State or Country), *Russia Poland*12-MAIDEN NAME OF MOTHER *Kate Goczyski*13-BIRTHPLACE OF MOTHER, (State or Country), *Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Modislous Gabor*(Address) *1817 Laureates*

15-

SEP - 5 1915

ROBERT KRAUTER,

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 3, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug. 25* 191*5*, to *Sept 3* 191*5*,that I saw him alive on *Sept 3* 191*5* and that death occurred, on the date stated above, at *10 30 a.m.*

The CAUSE OF DEATH* was as follows:

Eub. Colitis

CONTRIBUTORY (Secondary)

(Signed) *Wm. J. Gorman* M.D.

Sept 3, 1915

(Address) *2008 Calver*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Stanislaus*DATE OF BURIAL, *Sept 5, 1915*20-UNDERTAKER *W. A. Sadowski*ADDRESS *705 S. Ann*

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C87970

CERTIFICATE OF DEATH

115
REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 Light ST. 23 WARD)

2-FULL NAME

Beulah M. Thompson(Residence in Baltimore: No. 1610 LightSt.; 33 yrs. 1 mos. 27 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Single

6-DATE OF BIRTH

Aug. 1, 1882
(Month) (Day) (Year)

7-AGE

33 yrs. 1 mos. 2 ds. or min.?

If LESS than

1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)None9-BIRTHPLACE
(State or country)Balto. Md.

PARENTS

10-NAME OF FATHER

Thomas A. Thompson11-BIRTHPLACE OF FATHER
(State or country)Howard county Md.

12-MAIDEN NAME OF MOTHER

Mary A. Cook13-BIRTHPLACE OF MOTHER
(State or country)Balto. county Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Thom. A. Thompson

(Address)

1610 Light St.

15-

SEP - 5 1915

ROBERT KRAUTER
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 3, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 1, 1915, to, Sept 3, 1915that I saw him alive on Sept 3, 1915and that death occurred, on the date stated above, at 3:45 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac & respiratory
astheniaContributory
(SECONDARY)Acute coronary atherosclerosis
five jaguaries (Duration) yrs. mos. ds. 28(Signed) J. F. Newberry M.D.Sept 4, 1915 [Address] 18 Dundas St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Cem.

DATE OF BURIAL

9/5- 1915

20-UNDERTAKER

J. F. Newberry, 39 E. Fort

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1106 Russell*)ST. *21* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *William Battenburg*(Residence in Baltimore: No. *1106 Russell*)St. *20* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH,

Jan 16, 1856
(Month) (Day) (Year)

7-AGE,

59 yrs. 6 mos. 18 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Groceryman

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

John H Battenburg

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER,

Elizabeth Smith

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Battenburg(Address) *1106 Russell St.*

15-

SEP - 5 1915

ROBERT KRAUTER,
Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 4, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I attended deceased from

*Aug 1, 1915, to Sept 4, 1915,*that I saw him alive on *Sept 4, 1915,*and that death occurred, on the date stated above, at *4:30 p. m.*

The CAUSE OF DEATH* was as follows:

Stroke Paralysis(Duration) *15 mos. 15 ds.*

CONTRIBUTORY (Secondary)

(Duration) *9 mos. 15 ds.*(Signed) *W. M. C. Miller, M. D.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *15 yrs. 6 mos. 18 ds.* In the State *15 yrs. 6 mos. 18 ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

Sept. 7, 1915.

20-UNDERTAKER

William Cook

ADDRESS

502 E North Ave.

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 931 Burgundy St St.; 20 yrs., 00 mos., 00 ds.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 3, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1 1915, to Sept. 13 1915, that I saw him alive on Sept. 3 1915, and that death occurred, on the date stated above, at 4:10 am.

The CAUSE OF DEATH* was as follows:

Acute Encephalitis

CONTRIBUTORY... Wm. A.
(Secondary)
..... (Duration) yrs. mos. 2 ds.

(Signed) J. M. L. ... M. D. ...
Supp. 3, 1915 (Address) 826 N. ...

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
<i>London, Eng.</i>	<i>Sept. 5, 1917</i>

[illegible]

William Cook	502 E 112th
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HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1141 Nanticoke ST. 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William G. Dixon(Residence in Baltimore: No. 1141 Nanticoke St.; 47 yrs., 3 mos., 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH,

May 28, 1868
(Month) (Day) (Year)

7-AGE,

47 yrs., 3 mos., 7 ds.

If LESS than 1 day,hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Moulder
Stone

9-BIRTHPLACE, (State or Country),

Balto

10-NAME OF FATHER,

John C Dixon

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Mary Ann Kase

13-BIRTHPLACE OF MOTHER (State or Country),

Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary V. Dixon

(Address)

1141 Nanticoke

15-

SEP 5 1915

ROBERT KRAUTER
Baltimore City Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sep 4, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 3 1915, to Sept 4 1915, that I saw him alive on Apr 3 1915, and that death occurred, on the date stated above, at 640 a.m.

The CAUSE OF DEATH* was as follows:

Influenza Chronic

(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary)

(Duration)yrs.mos.ds.

(Signed) John C. Dixon M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Western Cemetery Sept. 6, 1915

20-UNDERTAKER

ADDRESS

William Cook 503 E. North a.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

13. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *21* WARD)

2-FULL NAME

(Residence in Baltimore: No. *914* *8 Carey St* St. *7* yrs. *—* mos. *—* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 10.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *white* 5-SINGLE MARRIED WIDOWED OR DIVORCED *Single* (Write the word)
6-DATE OF BIRTH *May* *23* *1898* (Month) (Day) (Year)
7-AGE *17* yrs. *3* mos. *11* ds. or min. *1* day, *—* hrs. *—* min. *?* If LESS than 1 day, hrs. min.?
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) *School boy*

9-BIRTHPLACE (State or country)

10-NAME OF FATHER
11-BIRTHPLACE OF FATHER (State or country)
12-MAIDEN NAME OF MOTHER
13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. J. Smith*
(Address) *Johns Hopkins Hosp*

15-

FILED

ROBERT KRAUTER,
Municipal Health Officer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept *4* *1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *August 23*, 191*5*, to, *September 4*, 191*5*, that I saw him alive on *September 4*, 191*5*, and that death occurred, on the date stated above, at *11:30* a.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Tibia
(Operation)

Contributory (SECONDARY)

(Duration) *2* yrs. *6* mos. *—* ds.
Sarcoma of mediastinum
(Duration) *2* yrs. *—* mos. *—* ds.
(Signed), *Verne R. Mason* M.D.
Sept 4, 191*5* [Address] *Johns Hopkins Hospital*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *12* yrs. *—* mos. *—* ds. In the *—* yrs. *—* mos. *—* ds. State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *914 8 Carey St*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Western *Sept 6*, 191*5*
Wombach *502 E. 7th*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

93 C87976

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 W. Lombard ST. 19 WARD)

2-FULL NAME Annalia E. Kilbourn

(Residence in Baltimore: No. 1427 W. Lombard St.; 50 yrs. 1 mos. 2 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE MARRIED Widowed WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH Aug (Month) 1 (Day) 1865 (Year)

7-AGE 50 yrs. 1 mos. 2 ds. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work Nurse (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore Md.

PARENTS 10-NAME OF FATHER Gilbert Lynning 11-BIRTHPLACE OF FATHER (State or country) N. J. 12-MAIDEN NAME OF MOTHER Mary Ann Collins 13-BIRTHPLACE OF MOTHER (State or country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Andrew E. Kilbourn (Address) 1427 W. Lombard St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept (Month) 3 (Day) 1915 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 30, 1915, to Sept 3, 1915, that I saw her alive on Aug 2, 1915, and that death occurred, on the date stated above, at 12:45 m. The CAUSE OF DEATH* was as follows:

Pleurisy

(Duration) yrs mos. 21 ds.

Contributory (SECONDARY)

(Duration) yrs mos. ds.

(Signed) H. E. Peltekian M. D. Sept 3, 1915 [Address] 817 Hamilton Terrace

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos. ds. In the State yrs mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Louisa Park Cem Sept 6, 1915

20-UNDERTAKER ADDRESS

Joe B Cook 1003 N. Baltimore

SEP - 5 1915

ROBERT K. KRAUTER

Filed 191

Bureau Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 25 yrs., 0 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

SEP - 5 1915

ROBERT

KRAUTER

Sur. Lat. Perrett, Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-I HEREBY CERTIFY, That I attended deceased from

July 22 1915 to Sept 4 1915

that I saw him alive on Sept 4 1915

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Typhoid fever
(Duration).....yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.mos.ds.

(Signed) Geo. H. Smarr M. D.

Sept 4, 1915 (Address) Franklin St. 25.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 14 ds. In the State yrs.mos.ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 914 Russell St.

19-PLACE OF BURIAL OR REMOVAL.

Trinity Cemetery

DATE OF BURIAL.

Sept. 7, 1915

20-UNDERTAKER

Joseph B Cook

ADDRESS.

1003 Wood

Baltimore &

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *300 Albermarl* ST.; *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *300 Albermarl* St.; *21* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

June (Month) *1869* (Year)

7-AGE,

46 yrs. mos. ds.

If LESS than 1 day. hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), *Italy*

PARENTS.

10-NAME OF FATHER,

*Don't know*11-BIRTHPLACE OF FATHER (State or Country), *Italy*

12-MAIDEN NAME OF MOTHER

*Don't know*13-BIRTHPLACE OF MOTHER (State or Country), *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Roberto*(Address) *300 Albermarl*

15-

Filed

SEP - 5 1915

ROBERT

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 2, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 31* 1915, to *Sep 2* 1915, that I saw him alive on *Sep 2* 1915, and that death occurred, on the date stated above, at *90* m. The CAUSE OF DEATH* was as follows:*acute Solen S pneumonia*(Duration) yrs. mos. ds. *4*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. S. Pessagno* D.*Sep 5* 1915 (Address) *213 Baltimore St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

Sept 5 1915

20-UNDERTAKER

Hendell W. Ypelson 378 mm

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87979

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87979

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1436 N. Fulton Ave. ST. 15 WARD)

2-FULL NAME Samuel G. Brown

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1436 N. Fulton Ave. St. 3 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE Married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH July 4 1880
(Month) (Day) (Year)

7-AGE 35 yrs. 2 mos. ds. or min.?
If LESS than 1 day, hrs., min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Driver
(b) General nature of industry, business, or establishment in which employed (or employer) Wien Wagon

9-BIRTHPLACE
(State or country) MD

10-NAME OF FATHER Franklin Brown

11-BIRTHPLACE OF FATHER MD

12-MAIDEN NAME OF MOTHER Mary McHenry

13-BIRTHPLACE OF MOTHER MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillian Brown

(Address) 1436 N. Fulton Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept. 4 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1915, to Sept. 3, 1915, that I saw him alive on Sept. 3, 1915, and that death occurred, on the date stated above, at 12:30 p.m.
The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY) Pneumonia
(Duration) yrs. mos. ds.

(Signed) E. William Fry M.D.
Sept. 4, 1915 [Address] 1928 Penn. Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL Sept. 5 1915

ADDRESS North Ave.

15- SEP - 5 1915

ROBERT . KRAUTER
Mortuary Permit Clerk
REGISTRAR

330 P. M.

C87980

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 C87980
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1410. Andre.* ST. *24* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME

(Residence in Baltimore: No. *1410. Andre.* St. *24* yrs. *2* mos. *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) *Single*

6-DATE OF BIRTH,

June 24, 1915
(Month) (Day) (Year)

7-AGE,

*2 mos. 11 ds.*If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

None
*Infant*9-BIRTHPLACE,
(State or Country),*Baltimore.*

PARENTS.

10-NAME OF FATHER,

Grants Prominski

11-BIRTHPLACE OF FATHER

(State or Country), *Germany.*

12-MAIDEN NAME OF MOTHER

Frances. Paczkowski

13-BIRTHPLACE OF MOTHER

(State or Country), *Russian Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Grants Prominski*(Address) *1410. Andre. St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 4, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Aug 20* 1915, to *Sept 4* 1915, that I saw him alive on *Sept 4* 1915, and that death occurred, on the date stated above, at *11 P* m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronch.(Duration) *2 mos. 11 ds.*CONTRIBUTORY
(Secondary)*Pulmonary edema.*(Duration) *3 ds.*(Signed) *Jas. J. O'Donnell* M. D.*Sept 5, 1915.* (Address) *107 E. West St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs. *2* mos. *11* ds. In the State *2* yrs. *2* mos. *11* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary.

DATE OF BURIAL,

Sept 6, 1915.

20-UNDERTAKER

William Fialkowski

ADDRESS

1618 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15-

Filed *SEP - 5 1915*

ROBERT K. KRAUTER

Bureau Permit Officer

Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87981

CERTIFICATE OF DEATH

80 C87981

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 3000 Clifton Ave

ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Marie Rosenbaum

(Residence in Baltimore: No. 2109 Callow Ave

St. 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6 DATE OF BIRTH

unknown, 1
(Month) (Day) (Year)

7 AGE

63

yrs.

mos.

ds.

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Phila. Pa.

10 NAME OF FATHER

Fox

PARENTS

11 BIRTHPLACE OF FATHER

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER

(State or country)

unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Rosenbaum

(Address) 2109 Callow Ave

15

SEP - 5 1915

ROBERT KRAUTER

Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 4th, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 1st, 1915, to, 1915,

that I saw her alive on Sept. 1st, 1915,

and that death occurred, on the date stated above, at 12:05 PM

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY)

Angina Pectoris

(Duration) yrs. mos. 3 ds

(Signed) Isaac C. Dickson M. D.

Sept. 4th, 1915 (Address) 3055 N. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Har Sinai Cpy

DATE OF BURIAL

Sept 6, 1915

20 UNDERTAKER

Wanda Soudherin

ADDRESS

118 N. W. Bond

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Childrens Hospital School*)ST.: *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Childrens Hosp School*)St.: *14* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

white

5-SINGLE,

MARRIED,

WIDOWED,

OR NEVER

(Write the word.)

6-DATE OF BIRTH

unknown, 190*1*
(Month) (Day) (Year)

7-AGE

14 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or Country)

10-NAME OF FATHER

William H. H. H.

11-BIRTHPLACE OF FATHER

(State or Country)

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hospital Records*

(Address)

15-

SEP - 5 1915

Filed....., 191.....

ROBERT E. KRAUTH

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

September 4th, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May, 191*5*, to *Sept 4*, 191*5*,that I saw him alive on *Sept 4*, 191*5*,and that death occurred, on the date stated above, at: *8 P* m.

The CAUSE OF DEATH* was as follows:

*Heart disease**Mitral Insufficiency**(Duration)..... yrs. mos. ds.*

CONTRIBUTORY

(Secondary)

(Duration)..... yrs. mos. ds.(Signed) *William J. J. J.* M. D.*Sept. 4, 1915.* (Address) *4 E. Madison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. mos. ds. In the *14* yrs. mos. ds. State *14* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Green Spring & 41st St.

19-PLACE OF BURIAL OR REMOVAL

Balti Helren

DATE OF BURIAL

Sept 6, 191*5*

20-UNDERTAKER

Hand Southern

ADDRESS

118 10 11 1/2 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87983

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 S. Poppleton ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 330 S. Poppleton St.; 59 yrs., .. mos. .. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Widow

6-DATE OF BIRTH.

Not known, 1855
(Month) (Day) (Year)

7-AGE.

60

yrs. .. mos. .. ds.

If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).None

9-BIRTHPLACE, (State or Country).

Born at sea

PARENTS.

10-NAME OF FATHER.

Not Known

11-BIRTHPLACE OF FATHER (State or Country).

Not Known

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER (State or Country).

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Francis Waible

(Address)

330 S. Poppleton

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept. 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 1915, to Sept. 2, 1915,
that I saw her alive on Sept. 2, 1915,
and that death occurred, on the date stated above, at 10.45 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of
Liver (Exploratory Laparotomy)
(Duration) .. yrs. .. mos. .. ds.

CONTRIBUTORY (Secondary)

Exhaustion
(Duration) .. yrs. .. mos. .. ds.

(Signed)

J. B. Lumsden M. D.
Sept. 4, 1915 (Address) 645 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. .. mos. .. ds. In the State .. yrs. .. mos. .. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

St. Peter's CemeterySept. 6, 1915

20-UNDERTAKER

ADDRESS

John J. Fields 1200 24th Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP - 5 1915

Filed

191

ROBERT L. KRAUTER,
Burial Permit Clerk

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1136 W. Pratt* ST.; *3* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1136 W Pratt* St.; *52* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Nov (Month) *1* (Day) *1847* (Year)

7-AGE,

67 yrs. *9* mos. *2* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None.*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Ireland

PARENTS.

10-NAME OF FATHER,

Tom Know

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Tom Know

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Margaret*(Address) *1136 W. Pratt St*

15-

SEP - 5 1915

Filed

101

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 3, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 23* 1915, to *Sept 3* 1915, that I saw him alive on *Sept 3* 1915, and that death occurred, on the date stated above, at *4 P* m.

The CAUSE OF DEATH* was as follows:

Hy postatic Pneumonia(Duration) ... yrs. ... mos. ... ds. *2 1/2*

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds. *Senility*(Signed) *M. H. O'Neill* M. D.*Sept 4, 1915* (Address) *108 N. Hollen Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St Peter

DATE OF BURIAL,

Sept 7, 1915

20-UNDERTAKER

John Fields 1200 W Lombard

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 N. Washington ST.; 6 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 20 N. Washington St.; 60 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, Married,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

April, 1855
(Month) (Day) (Year)

7-AGE

60 yrs., mos., ds.

IF LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

CareMaker9-BIRTHPLACE,
(State or Country),Balto.

10-NAME OF FATHER,

Michael Miller11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Agnes Miller

(Address)

20 N. Washington St.

15-

Filed.

SEP - 5 1915

191

ROBERT E. BRAUTER,
Surial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept, 4, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 9, 1915, to Sept 4, 1915,that I saw him alive on Sept 2, 1915,and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of throat
(Microscopic examination)(Duration) 1 yrs., mos., ds.CONTRIBUTORY
(Secondary)Carcinoma Throat(Signed) Geo. H. Miller M. D.7-4, 1915. (Address) 1737 Gough St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

Sept 7, 1915

20-UNDERTAKER

John Heenan Son

ADDRESS

901 H. H. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87986

HEALTH DEPARTMENT—CITY OF BALTIMORE

79
C87986

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1138 N. Carey street, ST. 16 WARD)

2-FULL NAME William E. Johnson,

(Residence in Baltimore: No. 1138 N. Carey street, St. 16, yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married, (Write the word.)

6-DATE OF BIRTH, Unknown, 1, (Month) (Day) (Year)

7-AGE, 55, 2, yrs., 2, mos., 2, ds., If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Butler, (b) General nature of industry, business, or establishment in which employed (or employer), Private family

9-BIRTHPLACE, (State or Country), Maryland,

10-NAME OF FATHER, Unknown,

11-BIRTHPLACE OF FATHER, (State or Country), Unknown,

12-MAIDEN NAME OF MOTHER, Unknown,

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Brown, friend,

(Address) 1138 N. Carey street,

15- SEP - 6 1915 HARRY O. ANDREWS, Registrar.

Filed, 191, Serial Permit, Alex

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 5th, 1915, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Organic heart disease, (Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Signed) Frederick Humpel, M. D. (Coroner.)

Sept. 5, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *11*)

REGISTERED No. C.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *220 W. Biddle St.*)St.: *20* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

....., *1*.....
(Month) (Day) (Year)

7-AGE,

46 yrs. *7* mos. *7* ds.If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Driver*
Express Wagon

9-BIRTHPLACE, (State or Country),

Va

PARENTS.

10-NAME OF FATHER,

Henry Harrison

11-BIRTHPLACE OF FATHER (State or Country),

Va

12-MAIDEN NAME OF MOTHER

Alice Jones

13-BIRTHPLACE OF MOTHER (State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Samuel J. Harrison*(Address) *18 S. B. Harrison St.*

15-

SEP - 6 1915

HARRY O. ANDREWS,

Filed.....

101

Supt. of Health, City of Baltimore

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 4, 191*5*
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Aug 29* 191*5*, to *Sept 4* 191*5*, that I saw him alive on *Sept 4* 191*5*, and that death occurred, on the date stated above, at *9:30 P. M.*

The CAUSE OF DEATH* was as follows:

Chronic Poisoning
(Duration)..... yrs. mos. *27* ds.CONTRIBUTORY (Secondary) *Chronic Nephritis & Arteriosclerosis*

(Duration)..... yrs. mos. ds.

(Signed) *Frank E. Hopkins, M. D.**Sept 4, 1915* (Address) *Med. Genl. Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. *7* ds. In the *20* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *220 W. Biddle St.*

19-PLACE OF BURIAL OR REMOVAL,

Waverly Va DATE OF BURIAL, *Sept 6, 1915*

20-UNDERTAKER

L. H. Brown & Son ADDRESS *108 W. Main St.**P.R.R. & Va*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Home Infirmary* ST.; *13* WARD)

2-FULL NAME

Mr John H Harrison(Residence in Baltimore: No. *7051 Woodbury Ave* City

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *70* yrs... mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*white*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

July 25, 1826
(Month) (Day) (Year)

7-AGE.

89 yrs... *1* mos... *12* ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...*Retired Merchant Gen*9-BIRTHPLACE,
(State or Country),*Wilmington*

10-NAME OF FATHER,

*John H Harrison*11-BIRTHPLACE OF FATHER
(State or Country),*MD*

12-MAIDEN NAME OF MOTHER

*ask not Given*13-BIRTHPLACE OF MOTHER
(State or Country),*MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm Harrison
(Address) *2704 Elm Ave*

15-SEP - 6 1915

HARRY O. ANDREWS,

Filed... 101... *Married Permit* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 6, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY: That I attended deceased from

*August 31, 1915, to Sept 6, 1915,*that I saw him alive on *Sept 6, 1915,*and that death occurred, on the date stated above, at *12:00am.*

The CAUSE OF DEATH* was as follows:

Pneumonia Acute(Duration) ... yrs... mos... *1* ds.CONTRIBUTORY
(Secondary)

(Duration) ... yrs... mos... ds.

(Signed) *G. A. Batten* M. D.*Sept 6, 1915* (Address) *Church Home Infirmary*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs... mos... *89* yrs... *1* mos... *12* ds. In the State...Where was disease contracted, *Church Home Infirmary*
if not at place of death?Former or usual residence *Church Home Infirmary*

19-PLACE OF BURIAL OR REMOVAL.

Beth Curing

DATE OF BURIAL.

Sept 8, 1915

20-UNDERTAKER

H Marshall 3539 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2223 E. Oliver*)2-FULL NAME *Elizabeth Schauf*(Residence in Baltimore: No. *2223 E. Oliver*)ST.: *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: _____ yrs., _____ mos., _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

December 31, 1937

(Month)

(Day)

(Year)

7-AGE,

*77 yrs. 8 mos. 3 ds.*If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House work

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

*Germany**Unknown**Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Frederick Schauf
2223 E. Oliver St.

15-SEP - 6 1915

HARRY O. ANDREWS,

Filed

191

Serial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 3, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from
that I saw him alive on *Sept 2* 1915,
and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma Pyloric End Bowel
(Clinical Diagnosis)

CONTRIBUTORY (Secondary)

Carcinomatosis
(Signed) Dr. F. C. Schauf
Sept 6, 1915 (Address) *1419 E. Bay St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Funeral Home
Christian Miller
2334 E. Bay St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87991

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203. *Neelwood av.* 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Willie M. Merson*(Residence in Baltimore: No. 1203 *Neelwood av.* St.; 19 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH.

Sept

(Month)

3 d

(Day)

1892

(Year)

7-AGE,

23

yrs.

mos.

da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*

9-BIRTHPLACE, (State or Country),

Brunswick Md

10-NAME OF FATHER,

Robert Smith

11-BIRTHPLACE OF FATHER (State or Country),

Brunswick Md

12-MAIDEN NAME OF MOTHER

Sarah Jefferson

13-BIRTHPLACE OF MOTHER (State or Country),

Winchester Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harvey E Merson

(Address)

1203 Neelwood av

15-

SEP - 6 1915

HARRY O. ANDREWS

Filed

191

Serial Permit Office

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept. 3rd, 1915
(Month) (Day) (Year)I HEREBY CERTIFY That I attended deceased from *Sept 1st* 1915 to *Sept 3rd* 1915that I saw him alive on *Sept 2nd* 1915 and that death occurred, on the date stated above, at *7:15* am.

The CAUSE OF DEATH* was as follows:

Exhaustion shock

CONTRIBUTORY (Secondary)

Cholera previous(Signed) *Samuel H. Merson* M. D.*1203 Neelwood av* (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Oliver Cemetery**Sept 6th*, 1915

20-UNDERTAKER

ADDRESS

Wm H Higdon 1001 N 37th

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87992

CERTIFICATE OF DEATH.

91

C87992

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Vincent's Inf. Asy.

ST. 14

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Henry Lawrence

(Residence in Baltimore: No.

St. Vincent's Infant Asylum St.;

yrs. mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

July

23

1915

(Month)

(Day)

(Year)

7-AGE,

yrs. 1 mos. 11 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) St. Vincent's

(Address) 1401 Division St.

15-

SEP - 6 1915

HARRY O. ANDREWS,

Marital Permit Clerk

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

4th

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 1st 1915, to Sept 4th 1915,

that I saw him alive on Sept 4th 1915,

and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John J. Farley M. D.

Sept. 4, 1915. (Address) 1223 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 26 ds. State yrs. 1 mos. 14 ds.

Where was disease contracted, if not at place of death? St. Vincent's Infant Asylum

Former or usual residence St. Vincent's Infant Asylum

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral

Sept. 6, 1915

20-UNDERTAKER,

ADDRESS

M. F. Ahern & Son, 1000 E. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be written EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 C87993
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infirmary* ST.: *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Dorothy Glenn(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs. *1* mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) *Single*

6-DATE OF BIRTH,

July 30th, 1915
(Month) (Day) (Year)

7-AGE,

yrs. *1* mos. *4* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country).*In England*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1701 Division St.*

15 SEP - 6 1915.

HARRY O. ANDREWS,

Filed..... 101... 21211. PAYM. K. Q. 101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 4th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 1st* 1915, to *Sept 4th* 1915, that I saw her alive on *Sept 4th* 1915, and that death occurred, on the date stated above, at *10:45 a.m.*

The CAUSE OF DEATH* was as follows:

M. abnutrition and M. al-assimilation(Duration)..... yrs. *1* mos. ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *John J. L...* M. D.*Sept 4th, 1915.* (Address) *1223 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *4* ds. In the State yrs. *1* mos. *4* ds.Where was disease contracted, if not at place of death? *St Vincent's Infant Asylum*Former or usual residence *St Vincent's Infant Asylum*

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Cathedral Sept 6, 1915

20-UNDERTAKER

ADDRESS

M. Fahney; 60606 Lafayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C87994

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87994

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

508 N Pulaski

ST.: 20 WARD)

REGISTERED NO. C

2-FULL NAME

Myra O Lowe

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

508 N Pulaski

St.: — yrs. 7 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH.

Jan 7, 1915

(Month)

(Day)

(Year)

7-AGE.

7 yrs. 7 mos. 28 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.

(State or Country),

Balt, Md

PARENTS.

10-NAME OF FATHER.

Charles E Lowe

11-BIRTHPLACE OF FATHER

(State or Country),

Balt, Md.

12-MAIDEN NAME OF MOTHER

Gladys Eugene

13-BIRTHPLACE OF MOTHER

(State or Country),

Balt, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. M. A. Brown

(Address)

508 N Pulaski, St.

15-

SEP - 6 1915

HARRY O. ANDREWS,

Filed

191

Registar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 5, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1915, to Sept 5, 1915,

that I saw him alive on Sept 4, 1915,

and that death occurred, on the date stated above, at 7:00 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) M. B. Brown and K. Koch M. D.

Sept. 5, 1915. (Address) 626 N. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Green Ridge Cemetery

Sept 6, 1915

20-UNDERTAKER

ADDRESS

Wm. H. Rouse

2000 E. Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 Barclay ST.: 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME

(Residence in Baltimore: No. 2224 Barkley St.: — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Widowed
(Write the word.)

6-DATE OF BIRTH

Aug 11, 1842
(Month) (Day) (Year)

7-AGE

73 yrs. 4 mos. 26 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....

SEP - 6 1915

HARRY O. ANDREWS,
Bureau of Health Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 5, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 30 1915, to Sept 5 1915,
that I saw her alive on " " 1915,

and that death occurred, on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease

(Duration) 10 yrs. 5 mos. 26 ds.

CONTRIBUTORY (Secondary)

(Duration) 10 yrs. 5 mos. 26 ds.

(Signed) E. J. Peterson, M. D.
Sept 5, 1915. (Address) Govans

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenwood Cemetery Sept 7, 1915.

20-UNDERTAKER

ADDRESS

Wm. E. Fuller, 221 N. Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C87996

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 2 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

8-LESS than 1 day, hrs. or min.?

9-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

10-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

HARRY O. ANDREWS,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry,

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address) 1724 W. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* St. *7* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)
2-FULL NAME *Robert L. Smithers*
(Residence in Baltimore: No. *Johns Hopkins Hospital* St. yrs. *1* mos. *26* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *white* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Single*
6-DATE OF BIRTH *January 16* (Month) (Day) *1915* (Year)
7-AGE *7* yrs. *18* mos. *18* ds. or min. If LESS than 1 day, hrs., min.
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) *none*

9-BIRTHPLACE (State or country) *Ind*

PARENTS
10-NAME OF FATHER *Robert L. Smithers*
11-BIRTHPLACE OF FATHER (State or country) *Va*
12-MAIDEN NAME OF MOTHER *Lillie Pair*
13-BIRTHPLACE OF MOTHER (State or country) *Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. J. Smith*

(Address) *Johns Hopkins Hosp*

15-

SEP - 6 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *September 4* (Month) (Day) *1915* (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 9*, 1915, to *September 4*, 1915, that I saw him alive on *September 4*, 1915, and that death occurred, on the date stated above, at *4 p.m.* The CAUSE OF DEATH* was as follows:
Leo Bolitis

Contributory (SECONDARY)

(Signed) *John G. Messer, Jr.* M. D. (Duration) yrs. *2* mos. *18* ds.
September 4, 1915 [Address] *Johns Hopkins Hosp*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. *1* mos. *26* ds. In the State yrs. *7* mos. *18* ds.

Where was disease contracted, if not at place of death? *—*

Former or usual residence *St Helena Ind*

19-PLACE OF BURIAL OR REMOVAL *Mt Carmel Am*

DATE OF BURIAL *Sept 6*, 1915

20-UNDERTAKER *Felix E. Ziller*

ADDRESS *403 S Wofers*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH OUPADING INK THIS IS A PERMANENT RECORD

C87998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C87998

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *411 N Parrish*)

ST. *19*

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Israel A Martin

(Residence in Baltimore: No. *411 N Parrish*)

St.; *—* yrs. *2* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Infant

6-DATE OF BIRTH

July 4, 1915
(Month) (Day) (Year)

7-AGE

2 yrs. *—* mos. *—* ds. If LESS than 1 day, *—* hrs. or *—* min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE (State or country)

Baltimore Md

10-NAME OF FATHER

Clarence Martin

11-BIRTHPLACE OF FATHER (State or country)

Baltimore Md

12-MAIDEN NAME OF MOTHER

Amelia Tusco

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. B. Fuddoch M.D.

(Address)

107 N. Carroll

15-SEP -6 1915, Filed

HARRY O. ANDREWS,

Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 4, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY. That I attended deceased from

Sept 3, 1915, to *Sept 4, 1915*

that I saw him alive on *Sept 4, 1915*

and that death occurred, on the date stated above, at *1 P.M.*

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) *—* yrs. *—* mos. *1* ds

Contributory (SECONDARY)

(Duration) *—* yrs. *—* mos. *—* ds.

(Signed)

J. B. Fuddoch M. D.

9/6, 1915

(Address) *117 N. Carroll*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Luke

DATE OF BURIAL

Sept 6, 1915

20-UNDERTAKER

Willie Brown

ADDRESS

306 N. Mount St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Clarkson ST. 23 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. H. Smith(Residence in Baltimore: No. 1707 Clarkson St.:

- yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Single

6-DATE OF BIRTH,

May 1, 1915
(Month) (Day) (Year)

7-AGE,

4 yrs., 3 mos., 3 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).None9-BIRTHPLACE,
(State or Country),Md.

10-NAME OF FATHER,

Geo. Smith11-BIRTHPLACE OF FATHER
(State or Country),Md.

12-MAIDEN NAME OF MOTHER

Dorothy Warbon13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Smith(Address) 1707 Clarkson

15-

SEP - 6 1915

HARRY O. ANDREWS,

Filed..... 191

Special Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 4, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from Aug 29, 1915, to Sept 4, 1915, that I saw him alive on Sept 4, 1915, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Infective Enteritis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) R. P. Campbell, M. D.Sept 5, 1915 (Address) 1644 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Cemetery Sept. 6, 1915.

20-UNDERTAKER

ADDRESS

Mr. J. E. Logan 1425 E. Schuylk
Dome St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88000		HEALTH DEPARTMENT—CITY OF BALTIMORE		C88000	
1-PLACE OF DEATH		CERTIFICATE OF DEATH		79 REGISTERED NO. C	
CITY OF BALTIMORE: (No. <u>1549</u> <u>Cole</u> ST. <u>14</u> WARD)		2-FULL NAME <u>Martin Byrnes</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
(Residence in Baltimore: No. <u>1549</u> <u>Cole</u> St. <u>40</u> yrs. <u>10</u> mos. <u>10</u> ds.)					
PERSONAL AND STATISTICAL PARTICULARS					
3-SEX <u>Male</u>	4-COLOR OR RACE <u>White</u>	5-SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)			
6-DATE OF BIRTH <u>Unknown</u>		(Month) (Day) (Year)			
7-AGE <u>65</u> yrs. <u>10</u> mos. <u>10</u> ds. or min.?		If LESS than 1 day, hrs. min.?			
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Laborer General</u>					
9-BIRTHPLACE (State or country) <u>Ireland</u>					
PARENTS					
10-NAME OF FATHER <u>Dennis Byrnes</u>					
11-BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>					
12-MAIDEN NAME OF MOTHER <u>Maryann Tooley</u>					
13-BIRTHPLACE OF MOTHER (State or country) <u>Ireland</u>					
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>Bridget Byrnes</u>					
(Address) <u>1549 Cole St</u>					
15-SEP - 6 1915 HARRY O. ANDREWS, REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16-DATE OF DEATH <u>September 5, 1915</u>					
(Month) (Day) (Year)					
17- I HEREBY CERTIFY, That I attended deceased from <u>June 1, 1914</u> , to <u>Sept 5, 1915</u> , that I saw him alive on <u>Sept 5, 1915</u> , and that death occurred, on the date stated above, at <u>108</u> m.					
The CAUSE OF DEATH* was as follows: <u>Endocarditis</u>					
18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]					
At place of death <u>1</u> yrs. <u>3</u> mos. <u>10</u> ds.					
Contributory (SECONDARY) <u>General</u> <u>Edema</u>					
(Signed) <u>Joseph E. Murre</u> M. D.					
[Address] <u>1520 Hollins</u>					
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2), whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
19-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]					
At place of death <u>1</u> yrs. <u>3</u> mos. <u>10</u> ds. State <u>1</u> yrs. <u>10</u> mos. <u>10</u> ds.					
Where was disease contracted, If not at place of death?					
Former or usual residence					
19-PLACE OF BURIAL OR REMOVAL <u>Cathedral Cemetery</u> DATE OF BURIAL <u>Sept 9, 1915</u>					
20-UNDERTAKER <u>John Horan</u> ADDRESS <u>901 Hollins</u>					

88001

HEALTH DEPARTMENT—CITY OF BALTIMORE

88001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 3 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *Jan 13, 1911*
(Month) (Day) (Year)

7-AGE, *7* yrs. *22* mos. *22* ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP - 6 1915

101.

HARRY O. ANDREWS,

Baltimore Permit Officer
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 5, 1911*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Sept 3* 1911, to *Sept 5* 1911, that I saw him alive on *Sept 5* 1911, and that death occurred, on the date stated above, at *2:30* p.m.

The CAUSE OF DEATH* was as follows:

*Enteric Colitis*CONTRIBUTORY
(Secondary)

(Signed) *W. J. Sadowski* M. D.
Sept 5, 1911 (Address) *2008 N. Howard St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

St. Stanislaus.

DATE OF BURIAL,

Sept 6, 1911.

20-UNDERTAKER,

M. J. Sadowski,

ADDRESS

705 S. Ann St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1546 Baylye* ST. *14* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1546 Baylye* wd. St. *Lifer* mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*6-DATE OF BIRTH. *Oct. 13th, 1872* (Month) (Day) (Year)7-AGE. *42* yrs. *10* mos. *21* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *House wife* (b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Balt. City*10-NAME OF FATHER, *Samuel T. Harris*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER *Bertha L. Perkins*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Flora D. Ford*(Address) *1546 Baylye wd.*

15-

Filed

SEP - 6 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Sept. 3*, 191*5*. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 1*, 191*3*, to *Sept. 3*, 191*5*, that I saw him alive on *Sept. 3d*, 191*5*, and that death occurred, on the date stated above, at *7:30* m. The CAUSE OF DEATH* was as follows:*Pne. T. B.* (Duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *A. Lee Ellis* M. D. *7/4*, 191*5*, (Address) *724 W. 1st St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt. Auburn Cem.* DATE OF BURIAL, *Sept. 6*, 191*5*.20-UNDERTAKER *John A. Treadwell* ADDRESS *142 W. 1st St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

088003

HEALTH DEPARTMENT—CITY OF BALTIMORE

088003

CERTIFICATE OF DEATH.

28
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1337 E North ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1337 E North ave St.; 9 yrs. 10 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Single

6-DATE OF BIRTH,

Oct. 10, 1872
(Month) (Day) (Year)

7-AGE,

42 yrs. 10 mos. 24 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).House
Keeper9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

George L Howard

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Margaret Brown

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Howard(Address) 1337 E North ave

15-

SEP - 6 1915

HARRY O. ANDREWS,

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 28 1915, to Sept 8 1915that I saw her alive on Sept 3 1915and that death occurred, on the date stated above, at 330 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 7 mos. 6 ds.CONTRIBUTORY
(Secondary)(Duration) 1 yrs. 7 mos. 6 ds.(Signed) Marshall F. Zimmerman M. D.Sept 6, 1915. (Address) 22 E. Boston St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 7 mos. 6 ds. In the State 1 yrs. 7 mos. 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenmount CemeterySept 6, 1915

20-UNDERTAKER

ADDRESS

George J. Ruth1735 Hayford

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88004

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88004

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Hebrew Hospital*)

REGISTERED No. C

ST. *3* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Bennie Cohen*

(Residence in Baltimore: No. *916 Watson*)

St. _____ yrs. *5* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Unknown*, 1
(Month) (Day) (Year)

7-AGE _____ yrs. *5* mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

8-OCCUPATION *none*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore*

10-NAME OF FATHER *Harry Cohen*

11-BIRTHPLACE OF FATHER (State or country) *Russia*

12-MAIDEN NAME OF MOTHER *Elsie Cohen*

13-BIRTHPLACE OF MOTHER (State or country) *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Harry Cohen
(Informant)

(Address) *916 Watson st*

15-SEP - 6 1915
Filed _____, 191_____

HARRY O. ANDREWS,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *September 5*, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug. 28*, 1915, to *Sept. 5*, 1915, that I saw him alive on *Sept. 5*, 1915, and that death occurred, on the date stated above, at *9 50 p. m.* The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(Duration) _____ yrs. _____ mos. *10* ds

Contributory (SECONDARY)

(Signed) *M. B. Levin* M. D.
Sept. 5, 1915 (Address) *Hebrew Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. *8* ds. *In the* _____ yrs. *5* mos. _____ ds.
Where was disease contracted, *916 Watson St*
If not at place of death?
Former or usual residence *916 Watson st*

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

John M. Carmel *Sept 6*, 1915

20-UNDERTAKER ADDRESS *1107 E*

S. Levinson & Co *Balto St*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

C88005

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 19 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 13.)

Sr.: Life time mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

Male

white

Single

6-DATE OF BIRTH

June 5th, 1915

7-AGE

3 mos.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE (State or country)

Baltimore

10-NAME OF FATHER

Fred C. Schreiber

11-BIRTHPLACE OF FATHER (State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Effie Bobbitt

13-BIRTHPLACE OF MOTHER (State or country)

Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Effie Schreiber

(Address) 1717 Lemon St.

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

Sept 5, 1915

17-I HEREBY CERTIFY, That I attended deceased from

July 1st, 1915, to Sept 5th, 1915

that I saw him alive on Sept. 4th, 1915

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Malnutrition (Ruminal
involvement)

Contributory (SECONDARY)

(Duration) yrs. 2 mos.

(Signed) Harry Goldberger

9-5, 1915 (Address) 2031 W. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bolivar Penna SEP 6 - 1915

20-UNDERTAKER

ADDRESS

Geo. A. Gerbig Baltimore

HARRY O. ANDREWS

REGISTRAR

SEP - 6 1915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2823 Hampden Ave.* St.; *13* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Luella P. Morgan*(Residence in Baltimore: No. *2823 Hampden Ave* St.; yrs., *3* mos. *26* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

June 9, 1915
(Month) (Day) (Year)

7-AGE.

3 mos. 26 da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

2723 Belmont St. Balto. Md.

10-NAME OF FATHER.

Perry Morgan

11-BIRTHPLACE OF FATHER

(State or Country), *Va.*

12-MAIDEN NAME OF MOTHER

Luella C. Hall

13-BIRTHPLACE OF MOTHER

(State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Perry Morgan*(Address) *2823 Hampden Ave.*

15-SEP - 7 1915

HARRY O. ANDREWS

Filed..... 191..... Permit..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept. 5, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 29* 1915, to *Aug 29* 1915, that I saw her alive on *Aug 29* 1915, and that death occurred, on the date stated above, at *7:45* m.

The CAUSE OF DEATH* was as follows:

Marasmus
Wheat of Breast Milk
(Duration)..... yrs. *3* mos. *26* da.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. da.
(Signed) *Richard C. Harley* M. D.
Sept. 6, 1915. (Address) *351 E. E. Street*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Laurel Md

DATE OF BURIAL,

Sept. 7, 1915

20-UNDERTAKER

Chenoweth Son

ADDRESS

Chestnut Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88008

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88008

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3524 Benson St. 13 WARD)

2-FULL NAME

(Residence in Baltimore: No. 3524 Benson St. 20 yrs. 0 mos. 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

(Write the word)

Widow

6-DATE OF BIRTH

July 3

1859

7-AGE

56 yrs.

2 mos.

2 ds.

If LESS than 1 day, 0 hrs. 0 min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

Baltimore City

10-NAME OF FATHER

Joe E. Coleman

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore City

12-MAIDEN NAME OF MOTHER

Rose B. Cropper

13-BIRTHPLACE OF MOTHER
(State or country)

Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie B. Brynndt

(Address) 3524 Benson St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September 5, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

September 5, 1915, to, Sept 5th 1915,
that I saw her alive on Sept 5, 1915,

and that death occurred, on the date stated above, at 8:20 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
(Producing Right Hemiplegia)

(Duration) 0 yrs. 0 mos. 0 ds.

Contributory
(SECONDARY)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) A. J. Shelley M. D.

Sept 6, 1915 [Address] Off. Shelley and

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 0 yrs. 0 mos. 0 ds. In the 0 yrs. 0 mos. 0 ds. State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmont

Sept 8, 1915

20-UNDERTAKER

ADDRESS

Chenoweth Son Chestnut

SEP - 7 1915

HARRY O. ANDREWS,

Marital Permit Clerk
REGISTRAR

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88009

CERTIFICATE OF DEATH

REGISTERED No. C.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. _____)

2-FULL NAME

(Residence in Baltimore: No. _____)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, _____ hrs.,
_____ mos., _____ ds., or _____ min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at P. M. A. M.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

15-

SEP - 7 1915

HARRY O. ANDREWS

REGISTRAR

Laurel Cemetery

Sept 7 1915

Chenoweth Son Chestnut Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88010

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital,
CITY OF BALTIMORE (No. Linden ave. & Madison st. ST. 11 WARD)

REGISTERED No. C

2-FULL NAME Elizabeth Simmont,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. Non-resident.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed,
(Write the word.)
6-DATE OF BIRTH, August 25th, 1859.
(Month) (Day) (Year)

7-AGE, 56 yrs. 0 mos. 11 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housewife,
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Frederick Sheppard,

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Margaret Gross,

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Simmont, son,

(Address) Landsdown, Balto; Co., Md.

15- SEP - 7 1915 HARRY O. ANDREWS,

Filed 101 Marial. Permit. Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 5th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry.....
(Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Signed) J. Frederick Sheppard M. D. (Duration).....yrs.....mos.....ds.

(Coroner) Sept. 6, 1915 (Address) 3310 W. North av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 15 minutes In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....
Landsdown, Balto; Co., Md.

Former or usual residence Landsdown, Md.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Olivet

Sept. 8, 1915

20-UNDERTAKER

ADDRESS

N. S. Pink

1921 14 Pratt St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *116 St. 22nd* ST.; *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *116 St. 22nd* St.; *66* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

October 4, 1847
(Month) (Day) (Year)

7-AGE,

*67 yrs. 11 mos. 0 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Photographer*9-BIRTHPLACE,
(State or Country),*New Jersey*

10-NAME OF FATHER,

*Abraham A Philips*11-BIRTHPLACE OF FATHER
(State or Country),*New Jersey*

12-MAIDEN NAME OF MOTHER

*Julia A. Shorey*13-BIRTHPLACE OF MOTHER
(State or Country),*New Hampshire*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Julia H. P. Braysshaw*(Address) *Fort George, Florida*

15-

SEP - 7 1915

HARRY O. ANDREWS,

121. Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 4, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug. 31, 1915* to *Sept. 4, 1915*, that I saw him alive on *Sept. 3rd, 1915*, and that death occurred, on the date stated above, at *6:35 a.m.*

The CAUSE OF DEATH* was as follows:

Exhaustion, Syncope

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Lobar Pneumonia with**Neuritic Effusion* yrs. mos. ds.(Signed) *Wm. Pillsbury* M. D.*Sept. 4, 1915* (Address) *2801 York Road*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

*CEDAR HILL.*DATE OF BURIAL
SEP 8 - 1915

20-UNDERTAKER

ARMSTRONG-DENNY CO.

ADDRESS

715 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88012

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1301 Division* ST. *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1301 Division* St.; *40* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*Married*

6-DATE OF BIRTH,

Not known, 1873
(Month) (Day) (Year)

7-AGE,

42 yrs. *1* mo. *1* da.If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic
*General*9-BIRTHPLACE,
(State or Country),*Md.*

10-NAME OF FATHER,

*Barney Sampson*11-BIRTHPLACE OF FATHER
(State or Country),*Ind.*

12-MAIDEN NAME OF MOTHER

*Margaret Colbert*13-BIRTHPLACE OF MOTHER
(State or Country),*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Oscar Hamilton
1301 Division St.
(Address)

15-

SEP - 7 1915
Filed..... 191.....

HARRY O. ANDREWS

Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 4th 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 27th 1915, to *Sept 4th 1915*that I saw her alive on *Sept 3rd 1915*and that death occurred, on the date stated above, at *5* p. m.

The CAUSE OF DEATH* was as follows:

acute indigestion
(Duration) ... yrs. ... mos. ... da.CONTRIBUTORY
(Secondary)*Acute Articular Rheumatism*
(Signed) *Harry O. Andrews* M. D.
Sept 6th 1915 (Address) *1501 Pressman*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Laurel Cemetery**Sept. 7, 1915*

20-UNDERTAKER

ADDRESS

*Robert A. Elliott**6th Rogers Lane*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str., yrs., mos., ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

16 LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-SEP -7 1915 HARRY O. ANDREWS

Filed 191. Social Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Signed) M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88014

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 C88014

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1134 Etting ST.: 14 WARD)

2-FULL NAME May Esther Allen

(Residence in Baltimore: No. 1134 Etting St.: Life mos. 11 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE Colored 5-SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH June 1 1913
(Month) (Day) (Year)

7-AGE 2 yrs 3 mos. 6 ds. or min. ? If LESS than 1 day, hrs., min. ?

8-OCCUPATION (a) Trade, profession or particular kind of work Baby (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto Md

10-NAME OF FATHER Thomas Allen

11-BIRTHPLACE OF FATHER (State or country) VA

12-MAIDEN NAME OF MOTHER Agatha Keffer

13-BIRTHPLACE OF MOTHER (State or country) VA

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agatha Allen

(Address) 1134 Etting

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept. 5 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 31, 1915, to, Sept 5 1915, that I saw her alive on Sept 4 1915, and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho
Pneumonia

Contributory (SECONDARY)

(Signed) E. William Fox M. D. Sept 6 1915 [Address] 1928 Penba. Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

1400 Auburn Sept 7 1915

20-UNDERTAKER

ADDRESS

James H. Durney 303 E. Enoch

SEP - 7 1915

HARRY O. ANDREWS,

Registrar

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

88015

HEALTH DEPARTMENT—CITY OF BALTIMORE

88015

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1440 N. Vincent street, ST. 15 WARD)

REGISTERED NO. C

FULL NAME

Harry Brown,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12L)

(Residence in Baltimore: No. 1440 N. Vincent street,

St. 15 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single,

6-DATE OF BIRTH, October 23d, 1889. (Month) (Day) (Year)

7-AGE, 25 yrs., 10 mos., 13 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Day laborer, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Walter Brown,

11-BIRTHPLACE OF FATHER (State or Country), Maryland,

12-MAIDEN NAME OF MOTHER, Emma Brown,

13-BIRTHPLACE OF MOTHER (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Brown, mother,

(Address) 1440 N. Vincent street.

15-SEP - 7 1915

Filed 191. HARRY O. ANDERSON Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 5th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, au-

... inquiry and that said deceased came to his death (Inquest, au-

opsy or inquiry.) on the day stated above. The CAUSE OF DEATH* was as follows:

Chronic alcoholism,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Campbell M. D. (Coroner.)

Sept. 6, 1915. (Address) 3310 W. North Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

James H. Dennis

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1834 Harford Ave* ST.; *9* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1834 Harford Ave* St.; *1* yrs., *5* mos. *4* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)
6-DATE OF BIRTH, *June 2*, 191*1*
(Month) (Day) (Year)
7-AGE, *1* yrs., *3* mos., *4* da. 10 LESS than 1 day.
...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balto. Md.*

10-NAME OF FATHER, *Bernard A. Wilkins*
11-BIRTHPLACE OF FATHER (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER, *Elizabeth Fell*
13-BIRTHPLACE OF MOTHER (State or Country), *Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm B. A. Wilkins*(Address) *1834 Harford Ave*

15- *SEP - 7 1915* HARRY O. ANDREWS, Registrar.
Filed *101* *Mar. 11. Permit. 011*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 8*, 191*5*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *Aug 27* 191*5*, to *Sept 8* 191*5*, that I saw her alive on *Sept 8* 191*5*, and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH* was as follows:

Indurated Mammary Glands
(Duration) *14* yrs., *14* mos., *14* da.

CONTRIBUTORY (Secondary) *Stomach*
(Duration) *14* yrs., *14* mos., *14* da.

(Street) *1834 Harford Ave* (Address) *Balto. Md.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer Cemetery* DATE OF BURIAL, *Sept 8*, 191*5*

20-UNDERTAKER, *Henry Horck* ADDRESS, *1301 E. Bayview*

WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. See instructions on back of certificate.
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

SEP - 7 1915

HARRY O. ANDREWS,

Sanitary Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 3 1915, to Sept. 4 1915,

that I saw him alive on Sept. 4 1915,

and that death occurred, on the date stated above, at 6:55 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward P. Smith M. D.

Sept. 4, 1915 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? On Board S.S. Wascana

Former or usual residence Norway

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Schwab Cemetery Sept. 7, 1915.

20-UNDERTAKER ADDRESS

Robert A. Turner 1442 N. Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88019

40 88019

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: NO. 1722 N Castle

ST.: 8 WARD)

REGISTERED NO. C

FULL NAME

William J Metz bower

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1722 N Castle

St.: 45 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH

July 3, 1858

7-AGE

57 yrs. 2 mos. 1 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Printer

9-BIRTHPLACE, (State or Country).

Md

10-NAME OF FATHER

John E Metz bower

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Emma A Kold

13-BIRTHPLACE OF MOTHER (State or Country).

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Katherine M Metz bower

(Address)

1722 N Castle St

15-SEP - 7 1915.

HARRY O. ANDREWS,

Filed

191

Marial Permib Clerk.

Registrar.

Dr Lehnert

1419 E Eager

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 4, 1915

17-I HEREBY CERTIFY, That I attended deceased from Aug 4 1915, to Sept 4 1915, that I saw him alive on Sept 4 1915, and that death occurred, on the date stated above, at 1205 P.m.

The CAUSE OF DEATH* was as follows:

Coronary artery disease
Chronic Myocarditis

CONTRIBUTORY (Secondary)

(Signed)

Sept 5, 1915 (Address) 1419 E Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Balto cem

DATE OF BURIAL,

Sept 7, 1915

20-UNDERTAKER

Wm Cook

ADDRESS

109 E. N. W.

N. B.—Every item of information should be carefully stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. 15 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and Tel. out No. 18.)

Srs. 30 yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married* (Write the word)

6-DATE OF BIRTH *Mar 14, 1872* (Month) (Day) (Year)

7-AGE *73* yrs. *6* mos. *24* ds. or *less* than 1 day, *hrs.* or *min.?*

8-OCCUPATION (a) Trade, profession, or particular kind of work *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Md. Freds Co*

10-NAME OF FATHER *Saul Mought*

11-BIRTHPLACE OF FATHER (State or country) *Md.*

12-MAIDEN NAME OF MOTHER *Nancy Adams*

13-BIRTHPLACE OF MOTHER (State or country) *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Robt A. Lahm* (Address) *3034 Baker St.*

15-SEP - 7 1915. HARRY O. ANDREWS, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept 8, 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 1913*, to *Sept 8, 1915*, that I saw him alive on *Sept 5, 1915*, and that death occurred, on the date stated above, at *9 a.m.* The CAUSE OF DEATH* was as follows:

Severe arteriosclerosis with progressive decline

(Duration) *2* yrs. *5* mos. *5* ds.

Contributory *Cerebral Hemorrhage*

(SECONDARY) *Respiratory Distress* (Duration) *5* yrs. *5* mos. *5* ds.

(Signed) *Wesley C. Cole* M. D.

Sept 6, 1915 (Address) *2202 Garrison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *1* yrs. *5* mos. *5* ds. In the State *1* yrs. *5* mos. *5* ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Frederick Med. Co. *Sept 8, 1915*

20-UNDERTAKER ADDRESS

W. Burroughs *1423 W. Lafayette St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88021

CERTIFICATE OF DEATH.

64 C88021
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1265 Columbia ave ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1265 Columbia ave St.; Lifetime ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

Single

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

about 73

yrs. mos. ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Clerk
office work

9-BIRTHPLACE,

(State or Country),

Balt

10-NAME OF FATHER,

Adam List

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lilly Schlockerman

(Address)

1265 Columbia

15-

SEP - 7 1915

HARRY O. ANDREWS,

Filed

191

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

5th

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 5, 1915, to 191

that I saw him alive on Sept 5th 1915,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

15 minutes

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

old age

(Duration) yrs. mos. ds.

(Signed)

Shepherd Drain M. D.

1227 Columbia St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

Sept 7, 1915

20-UNDERTAKER

W. J. McKnight

ADDRESS

Remax 11111

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88023

CERTIFICATE OF DEATH.

151 C88023
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1220 S. Ellwood ave* ST.; *11* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

6 month Fetus
(Residence in Baltimore: No. *1220 S. Ellwood ave* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE,

single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Sept 5, 1915
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day.

...hrs. or *15* min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Tyler Harmon*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*May Meek*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

SEP - 7 1915.

HARRY O. ANDREWS,

Serial Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 5, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Sept 5, 1915* to *Sept 5, 1915*, that I saw him alive on *Sept 5, 1915*, and that death occurred, on the date stated above, at *1:15 a.m.*

The CAUSE OF DEATH* was as follows:

6 month Fetus
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *H. B. Titlow* M. D.*Sept 5, 1915* (Address) *3635 Booneville St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

COLLEGE OF P. & S.

DATE OF BURIAL,

SEP 6, 1915

20-UNDERTAKER

Commissioner Health,

ADDRESS

Per. Wm. E. WOODALL

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88024 HEALTH DEPARTMENT—CITY OF BALTIMORE

C88024

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 Belmont ST. 18 WARD)

2-FULL NAME

Residence in Baltimore: No. 236 Belmont St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Black

5-SINGLE,

MarriedWidowedOr Divorced

(Write the word)

6-DATE OF BIRTH

Aug 29, 1915
(Month) (Day) (Year)

7-AGE

0 yrs. 0 mos. 1 ds.

If LESS than 1 day,

..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

SEP - 7 1915

HARRY O. ANDREWS,

Filed..... 191. Marial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 30, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
8 29 1915, to 8 30 1915,that I saw her alive on 8 29 1915,and that death occurred, on the date stated above, at 8 12 m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

..... (Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

..... (Duration)..... yrs. mos. ds.

(Signed) P. L. Rush M. D.1....., 1915. (Address) University Hall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

COLLEGE OF P. & S,

DATE OF BURIAL

SEP 4 1915

20-UNDERTAKER

Commissioner Health,

ADDRESS

MR. W. L. WOODALL.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88025

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88025

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

Hebrew Hospital

ST.:

WARD)

FULL NAME

Mathias Schellenschlager

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

(Residence in Baltimore: No.

810 N. Wolfe St

St.:

yrs.

5

mos.

19

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single

6 DATE OF BIRTH

Mar 19, 1915

7 AGE

5 yrs. 5 mos. 19 ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

Maryland City

PARENTS

10 NAME OF FATHER

Mathias Schellenschlager

11 BIRTHPLACE OF FATHER (State or country)

Balto City

12 MAIDEN NAME OF MOTHER

Eva I. Constance

13 BIRTHPLACE OF MOTHER (State or country)

Balto City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eva I. Schellenschlager

(Address)

810 N. Wolfe St.

SEP - 7 1915

HARRY O. ANDREWS,

Filed

191

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

September 7, 1915

17. I HEREBY CERTIFY. That I attended deceased from Aug. 16, 1915, to Sept. 7, 1915, that I saw him alive on Sept. 7, 1915, and that death occurred, on the date stated above, at 2:55 A. M. The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

M. B. Levine

M. D.

Sept 7, 1915

(Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 22 ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

810 N. Wolfe St

Former or

usual residence

810 N. Wolfe St

19 PLACE OF BURIAL OR REMOVAL

Balto Cemetery

DATE OF BURIAL

Sept 9, 1915

20 UNDERTAKER

Albert E. Fuller

ADDRESS

221 N Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Jessa Shaldoffer

C88026 HEALTH DEPARTMENT—CITY OF BALTIMORE 51 C88026

CERTIFICATE OF DEATH

1-PLACE OF DEATH *Home of the Good Shepherd* REGISTERED No. C

CITY OF BALTIMORE (No. *Hollins & Mount* ST. *19* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Sister Jessa Shaldoffer*

(Residence in Baltimore: No. *House of Good Shepherd* St. *20* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3-SEX <i>Female</i>	4-COLOR OR RACE <i>White</i>	5-SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Single</i>	10-DATE OF DEATH <i>Sept 6th, 1915</i>	
6-DATE OF BIRTH <i>Sept 6th, 1868</i>			17- I HEREBY CERTIFY, That I attended deceased from <i>Sept 2nd, 1915</i> to <i>Sept 6th, 1915</i> that I saw her alive on <i>Sept 6th, 1915</i> and that death occurred, on the date stated above, at <i>m.</i> The CAUSE OF DEATH* was as follows:	
7-AGE <i>47</i> yrs. mos. ds. or min.?			<i>Exophthalmic Goiter.</i>	
8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)			<i>6 months</i> (Duration) yrs. mos. ds.	
9-BIRTHPLACE (State or country) <i>Germany</i>			Contributory (SECONDARY) <i>Intestinal Catarrh</i>	
PARENTS	10-NAME OF FATHER <i>Unknown</i>		(Signed) <i>E. J. Mulholland, M. D.</i>	
	11-BIRTHPLACE OF FATHER (State or country) <i>Germany</i>		, 191 (Address) <i>115 W. Franklin</i>	
	12-MAIDEN NAME OF MOTHER <i>Unknown</i>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.	
13-BIRTHPLACE OF MOTHER (State or country) <i>Germany</i>			18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Sisters of Good Shepherd</i> (Address) <i>Shepherd</i>			At place of death <i>20</i> yrs. mos. ds. In the State <i>MD</i> yrs. ds. Where was disease contracted, if not at place of death <i>House of Good Shepherd</i> Former or usual residence <i>House of Good Shepherd</i>	
15- <i>SEP - 7 1915</i> HARRY O. ANDREWS, Registrar			19-PLACE OF BURIAL OR REMOVAL <i>Good Shepherd Cem.</i> DATE OF BURIAL <i>Sept 18, 1915</i>	
			20-UNDERTAKER <i>John J. Haladous</i> ADDRESS <i>314 E. Light</i>	

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88027

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *3111 Foster Ave.* ST. *1* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *3111 Foster Ave.* St. *1* Yrs. *1* mos. *14* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

Dec 30th 1911
(Month) (Day) (Year)

7-AGE,

*3 yrs. 8 mos. 6 ds.*If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE,

(State or Country),

Baltimore City.

PARENTS.

10-NAME OF FATHER,

Fredrick L. Wapson

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore City.

12-MAIDEN NAME OF MOTHER

Clara Sebour.

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore City.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Fredrick L. Wapson*(Address) *3111 Foster Ave.*

15-

SEP - 7 1915

HARRY O. ANDREWS,

Serial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 7, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

*Sept 5 1915, Sept 7 1915*that I saw him alive on *Sept 6 1915*and that death occurred, on the date stated above, at *12:30 p.m.*

The CAUSE OF DEATH* was as follows:

Diphtheria(Duration) *14* yrs. *14* mos. *14* ds.

CONTRIBUTORY

(Secondary)

(Duration) *14* yrs. *14* mos. *14* ds.(Signed) *H. B. Vetter* M. D.*Sept. 7, 1915* (Address) *303 S. Odome St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs. *1* mos. *14* ds. In the State *1* yrs. *1* mos. *14* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Sacred Heart Ch.

DATE OF BURIAL,

Sept. 7, 1915

20-UNDERTAKER

Lilly and Ziehl

ADDRESS

*203 S. W. 1st St.**4 P.M. Sept. 7-1915*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88028

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175

C88028

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *John Hopkins Hosp* ST. *1* WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. *827 S Montford Ave* St.: yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widowed* (Write the word.)

6-DATE OF BIRTH, *Aug 2nd 1858* (Month) (Day) (Year)

7-AGE, *57* yrs. *1* mos. *3* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Carpenter* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *md*

10-NAME OF FATHER, *William Busch*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Caroline Miller*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edw Lutz*

(Address) *403 S. Wolfe St*

15- SEP - 7 1915 HARRY O. ANDREWS, 191 Serial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 5th 1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

(Accident) Fractured skull and Fractured Ribs

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY *Run over by a horse* (Secondary)

(Signed) *Edw Lutz* (Duration) ... yrs. ... mos. ... ds.

(Coroner.) M. D.

Sept 5th 1915 (Address) *403 S. Wolfe St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death, ...

Batman Ave Road

Former or usual residence *827 S Montford Ave*

19-PLACE OF BURIAL OR REMOVAL, *Schwartz's* DATE OF BURIAL, *Sept 7 1915*

20-UNDERTAKER, *Lutz & Ziehl* ADDRESS, *403 S. Wolfe St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88029

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital* 4
 CITY OF BALTIMORE: (No. *4* ST.; *4* WARD)
 2-FULL NAME *J. Robert May*
 (Residence in Baltimore: No. *University Hospital* St.; *3* yrs., *3* mos. *3* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
 6-DATE OF BIRTH, *Sept 30th 1855*
 (Month) (Day) (Year)

7-AGE, *59* yrs., *11* mos., *5* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Farmer*
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Ind. Maryland*

PARENTS.
 10-NAME OF FATHER, *J. P. May*
 11-BIRTHPLACE OF FATHER (State or Country), *Ind. Maryland*
 12-MAIDEN NAME OF MOTHER *Martha Muller*
 13-BIRTHPLACE OF MOTHER (State or Country), *Ind. Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. P. May*
 (Address) *1111 1/2 Hall St.*

15-SEP - 7 1915
 Filed.....
 REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 5*, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept 2* 1915, to *Sept 5* 1915, that I saw him alive on *Sept 5* 1915, and that death occurred, on the date stated above, at *5:40 pm*. The CAUSE OF DEATH* was as follows:

Myocarditis - Endocarditis

Several years
 (Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary) *Acute Exacerbation*

(Duration)..... yrs. mos. ds.

(Signed) *W. H. Lewis* M. D.
Sept 5, 1915. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VOLUNT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the *Life* State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Glencoe, Md.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Hereford Baltimore Md *Sept 8 1915*

20-UNDERTAKER ADDRESS

W. J. Kins & Son Co *McLulloch*

Date of Burial *Sept 8 1915* *9-8-15*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

333 E 70"

ST.:

12

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary R. Egerlon

(Residence in Baltimore: No.

333 E 70"

St.; 50 yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

widow

3-DATE OF BIRTH,

June 21, 1850

(Month)

(Day)

(Year)

7-AGE,

65 yrs. 2 mos. 16 ds.

If LESS than 1 day,

...hrs. or...mins.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

At home

9-BIRTHPLACE,
(State or Country).

St Mary's Co Md

10-NAME OF FATHER,

Hilery Cowler

11-BIRTHPLACE OF FATHER
(State or Country).

St Mary's Co

12-MAIDEN NAME OF MOTHER

Julia Morgan

13-BIRTHPLACE OF MOTHER
(State or Country).

St Mary's Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Miss Maudy Egerlon

(Address)

333 E 70" St

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 6

(Month)

(Day)

1915-
(Year)

17- I HEREBY CERTIFY, That I attended deceased from April 8 1915, to Sept 6 1915; that I saw her alive on Sept 6 1915; and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Pericardial Effusion +
Chronic Infection of mouth.

(Duration)

6 mos. - ds.

CONTRIBUTORY
(Secondary)

(Duration)

3 mos. - ds.

(Signed)

J. F. Zimmerman

M. D.

Sept 7, 1915. (Address) 22 E Preston St.

(State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenmount

Sept 8, 1915

20-UNDERTAKER

ADDRESS

William Cook 307 E Noan

15-

SEP - 7 1915

Filed

ROBERT BRAUTER

Bureau of Public Health

Registrar.

Dr Beck 29 E Preston

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST.; *15* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Epiphany College* St.; *72* yrs., *7* mos. *15* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*white*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

March 23, *1893*
(Month) (Day) (Year)

7-AGE,

22 yrs. *5* mos. *15* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work. *Student*
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....9-BIRTHPLACE,
(State or Country),*Pa*10-NAME OF
FATHER,*Wm. Landy*11-BIRTHPLACE
OF FATHER
(State or Country),*Ireland*12-MAIDEN NAME
OF MOTHER*Mary J. Grant*13-BIRTHPLACE
OF MOTHER
(State or Country),*England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. M. Cooley*(Address) *Waltham St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 7, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 30 191*5*, to *Sept 7* 191*5*,that I saw him alive on *Sept 7* 191*5*and that death occurred, on the date stated above, at *1 a.* m.

The CAUSE OF DEATH* was as follows:

tuberculosis intestines

.....

.....

..... (Duration) *not known* yrs. mos. ds.CONTRIBUTORY
(Secondary)..... (Duration) *7* yrs. mos. ds.(Signed) *K. M. Gallagher* M. D.*917*, 191*5*. (Address) *St. Joseph's Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *7* ds. In the State *38* yrs. mos. ds.Where was disease contracted, if not at place of death? *Not known*Former or usual residence *Epiphany College*

19-PLACE OF BURIAL OR REMOVAL,

Cathedral

DATE OF BURIAL,

Sept 9, 191*5*.

20-UNDERTAKER

M. Mahoney & Sons

ADDRESS

608 Lafayette St.

15-

SEP - 7 1915

Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88032

C88032

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *440 N Biddle*)

ST. *11* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Kamiron Brown

(Residence in Baltimore: No. *440 N Biddle*)

St. *11* yrs. *2* mos. *13* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

June 23, 1898
(Month) (Day) (Year)

7 AGE

27 yrs. *2* mos. *13* ds. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer (Day)

9 BIRTHPLACE (State or country)

Baltimore City

10 NAME OF FATHER

William Brown

11 BIRTHPLACE OF FATHER (State or country)

md

12 MAIDEN NAME OF MOTHER

Annie Taylor

13 BIRTHPLACE OF MOTHER (State or country)

md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Maggie Aikton*

(Address) *440 N Biddle*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

9 *5*, 191*5*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug 22, 1915 to *Sept 5, 1915*

that I saw him alive on *Sept 5, 1915*

and that death occurred, on the date stated above, at *8:00 p.m.*

The CAUSE OF DEATH* was as follows:

Albuminuria

Contributory (SECONDARY)

Acute Nephritis
(Duration) yrs. mos. *15* ds.

(Signed)

Sept 7, 1915 (Address) *1202 N Hill Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

St Auburn

DATE OF BURIAL

Sept 8, 1915

20 UNDERTAKER

Sam'l J. Hensley

ADDRESS

578 N Biddle

SEP 7 - 1915

Filed, 191

ROBERT KRAUTH

Notary Public

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88033

CERTIFICATE OF DEATH

64

C88033

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1116 South Am*)

ST. *18* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Sarah Pierce*

(Residence in Baltimore: No. *1116 South Am St.* *25* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) *Widow*

6-DATE OF BIRTH

Unknown, 1855
(Month) (Day) (Year)

7-AGE

60 yrs. mos. ds. or min. *7* If LESS than 1 day,hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Cook

9-BIRTHPLACE (State or country)

Maryland

PARENTS

10-NAME OF FATHER

Jacob French

11-BIRTHPLACE OF FATHER (State or country)

md

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ethel M. Taylor

(Address)

705 N. Franklin

15

SEP - 7 1915

ROBERT J. KRAUTH

Burial Permit Officer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept *6*, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 15*, 1915, to *Sept 6*, 1915, that I saw him alive on *Aug 29*, 1915, and that death occurred, on the date stated above, at *11:10* m. The CAUSE OF DEATH* was as follows:

Atherosclerosis

(Duration) *7* yrs. mos. ds.

Contributory (SECONDARY)

Hypertension

(Duration) *24* yrs. mos. ds.

(Signed)

J. L. Horner

M. D.

Sept 6, 1915 (Address) *910 N. Fayette*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Ambrose

DATE OF BURIAL

Sept 8, 1915

20-UNDERTAKER

Carl L. Hensley

ADDRESS

578 W. Biddle

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf't Asy.* ST.: *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Fidelis Morgan(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs. *2* mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH,

July 3rd, 1915
(Month) (Day) (Year)

7-AGE,

*2 yrs. 2 mos. 2 ds.*If LESS than 1 day.
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

ROBERT KRAUTER

Filed

SEP - 7 1915

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 5th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 1st* 1915, to *Sept 5th* 1915, that I saw him alive on *Sept. 5th* 1915, and that death occurred, on the date stated above, at *11:00 P. m.*

The CAUSE OF DEATH* was as follows:

Congenital Syphilis(Duration) *2 yrs. 2 mos. 2 ds.*CONTRIBUTORY
(Secondary)(Duration) *2 yrs. 2 mos. 2 ds.*(Signed) *John S. Farby* M. D.*Sept 6, 1915* (Address) *1223 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. *2* ds. In the State yrs. *2* mos. *2* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

St Vincent's Inf Asylum

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral**Sept 7, 1915*

20-UNDERTAKER

ADDRESS

*M. Farby & Sons**606 Lafayette St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

862 Vine St.

REGISTERED No. C

CITY OF BALTIMORE: (No.

ST.;

WARD)

2-FULL NAME

Rosie Roland

(Residence in Baltimore: No.

862 Vine St.

St.;

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

female

4-COLOR OR RACE,

Black.

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Sept.

5

1915

(Month)

(Day)

(Year)

7-AGE,

8 hours

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Maryland. Balt.

10-NAME OF FATHER,

Grant Roland

11-BIRTHPLACE OF FATHER

(State or Country),

N. Carolina

12-MAIDEN NAME OF MOTHER

Rosie Sutton

13-BIRTHPLACE OF MOTHER

(State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Thomps R. Lohm

(Address)

Mercy Hospital

15-

16-

SEP - 7 1915

HUBERT A. BRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 6

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 5 1915, to Sept. 6 1915,

that I saw her alive on Sept. 5 1915,

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Septicemia
 (Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward J. Smith, M. D.

Sept. 6, 1915 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 862 Vine St.

Former or usual residence 862 Vine St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Auburn

Sept. 7, 1915

20-UNDERTAKER

ADDRESS

John H. Tordella

1420 W. 11th St.

18- Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *20 E. Hamburg* ST. *23* WARD)

2 FULL NAME

Joseph E. Duckett

(Residence in Baltimore: No. *20 E. Hamburg St.* St. *50* yrs. *50* mos. *50* ds.)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Widow*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *July 71, 1840*
(Month) (Day) (Year)

7-AGE *75* yrs. *1* mos. *15* ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION
(a) Trade, profession or particular kind of work *Domestic*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Washington Dc.*

10-NAME OF FATHER *Thos Mitchell*

11-BIRTHPLACE OF FATHER (State or country) *Washington Dc.*

12-MAIDEN NAME OF MOTHER *Don't know*

13-BIRTHPLACE OF MOTHER (State or country) *Don't know*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William Duckett*

(Address) *20 E. Hamburg St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept 6, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 1, 1915* to *Sept 6, 1915*, that I saw him alive on *Sept 5, 1915*, and that death occurred, on the date stated above, at *3:30* p.m.
The CAUSE OF DEATH* was as follows:

Infirmities of old age.
(Duration) yrs. mos. ds.

Contributory (SECONDARY)
(Duration) yrs. mos. ds.
(Signed) *J. E. Smith* M. D.
Sept 7, 1915 [Address] *910 Light St*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Mt. Olivet Cem* DATE OF BURIAL *9/8, 1915*

20-UNDERTAKER *J. F. McConally* ADDRESS *39 E. ...*

15-SEP - 7 1915. ROBERT KRAUTER, REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2215 Chelara Ave ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Robert Tilmore Read(Residence in Baltimore: No. 2215 Chelara AveSt.; 67 yrs., 3 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-STATUS, unmarried
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

May
(Month)26
(Day)1848
(Year)

7-AGE,

67 yrs., 3 mos., 9 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Real estate agent

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Robert Read11-BIRTHPLACE OF FATHER
(State or Country).Baltimore Md.

12-MAIDEN NAME OF MOTHER

Ellen Herritt13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophia H. Read(Address) 2215 Chelara Ave. (Halt)15-
SEP - 7 1915

Filed

191

JOSEPH KRAUTER,Deputy Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 5, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Sept. 3 1915, to Sept. 5 1915,
that I saw h i alive on Sept 5 1915,
and that death occurred, on the date stated above, at 1:45 P m.

The CAUSE OF DEATH* was as follows:

Acute glomerulonephritis +
parenchymatous
nephritis
(Duration) ? yrs. ? mos. ? ds.CONTRIBUTORY
(Secondary)Nephritis
(Duration) ? yrs. ? mos. ? ds.(Signed) Walter S. Kibbitt M. D.
Sept 7, 1915. (Address) Chelara Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Greenmount CemeteryDATE OF BURIAL, Sept 8, 1915.

20-UNDERTAKER

H. E. Hughes

ADDRESS

17 S. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hospital Baltimore* ST. *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1609 Jackson* St. *16* yrs. *2* mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE,

*Married**Widowed**OR DIVORCED,*

(Write the word.)

6-DATE OF BIRTH,

November 1, 1877

(Month)

(Day)

(Year)

7-AGE,

37 yrs. 10 mos. 2 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Rail road

(b) General nature of industry, business, or establishment in which employed (or employer).

Engineer

9-BIRTHPLACE,

(State or Country).

Washington Co Md.

10-NAME OF FATHER,

George H. Benjamin

11-BIRTHPLACE OF FATHER

(State or Country).

London Co. Va

12-MAIDEN NAME OF MOTHER

Lavenia Hardy

13-BIRTHPLACE OF MOTHER

(State or Country).

London Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Lavenia Benjamin*(Address) *1609 Jackson St.*

15-

SEP - 7 1915

ROBERT C. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 4, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 22 1915, to September 4 1915,*that I saw him alive on *September 4 1915,*and that death occurred, on the date stated above, at *67* m.

The CAUSE OF DEATH* was as follows:

*Lobar pneumonia**Acute hemorrhagic*(Duration) *3* yrs. *1* mos. *12* ds.CONTRIBUTORY *Acute hemorrhagic*(Secondary) *Pneumonia*(Duration) *1* yrs. *1* mos. *12* ds.(Signed) *J. W. V. Cliff* M. D.*Sept 4 1915* (Address) *St. Joseph Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs. *12* mos. *12* ds. In the State *1* yrs. *1* mos. *12* ds.Where was disease contracted, if not at place of death? *Home*Former or usual residence *1609 Jackson St.*

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL,

Sept 8, 1915

20-UNDERTAKER

A. C. Myhr 17 St. Body

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

088039

HEALTH DEPARTMENT—CITY OF BALTIMORE

088039

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *105 N. Vincent*

ST. *19*

WARD)

2-FULL NAME *Caleb Woods*

(Residence in Baltimore: No. *105 N. Vincent*

28
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

40
St.: yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED, *Married*

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

unknown, *1868*
(Month) (Day) (Year)

7-AGE,

47

Yrs. mos. da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Day Laborer

9-BIRTHPLACE, (State or Country),

MD

10-NAME OF FATHER,

Thomas J. Woods

11-BIRTHPLACE OF FATHER (State or Country),

MD

12-MAIDEN NAME OF MOTHER

Virginia Chase

13-BIRTHPLACE OF MOTHER (State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Virginia Woods*

(Address) *105 N. Vincent St.*

15-

SEP - 7 1915

191

ROBERT KRAUTER,
Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 4th 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) *Samuel H. Smith*

(Coroner)

Sept 7th 1915

(Address) *2302 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Andrew

Sept 8, 1915

20-UNDERTAKER

ADDRESS *306 W. Mount St.*

Wilbert Brown

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88040

CERTIFICATE OF DEATH

X102

C88040

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. Hebrew Hospital ST. 7 WARD)

2-FULL NAME James Lawrence Schell

(Residence in Baltimore: No. Hebrew Hospital Sr. yrs. plus mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED single (Write the word)

6-DATE OF BIRTH May 15, 1891 (Month) (Day) (Year)

7-AGE 24 yrs. 3 mos. 23 ds. or less than 1 day, hrs. min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Electrician (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Belair Md

10-NAME OF FATHER Frederick J. Lonell

11-BIRTHPLACE OF FATHER (State or country) Harford Co.

12-MAIDEN NAME OF MOTHER Annie M. Kee

13-BIRTHPLACE OF MOTHER (State or country) Harford Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick J. Schell

(Address) Belair Md

15-SEP - 7 1915. ROBERT KRAUTER

Filed 1915. Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH September 7, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I attended deceased from September 7, 1915 to Sept 7, 1915 that I saw him live on Sept 7, 1915 and that death occurred, on the date stated above, at 7:15 PM. The CAUSE OF DEATH* was as follows: Perforation of stomach

Contributory (SECONDARY) Pneumonia (Duration) yrs. mos. ds.

(Signed) M. B. Levee M. D. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 4 hrs. in the State yrs. mos. ds. Where was disease contracted, Belair Md If not at place of death? Former or usual residence Belair Md

19-PLACE OF BURIAL OR REMOVAL Belair Md

20-DATE OF BURIAL Sept 7, 1915

21-UNDERTAKER Nathaniel C. Eber

ADDRESS 1944 W. North

C88041

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88041

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2026 Booth*)ST.: *70* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *2026 Booth*)

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH

August 12, 1915
(Month) (Day) (Year)

7-AGE

26
yrs. mos. ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*None*9-BIRTHPLACE,
(State or Country),*Balto*

10-NAME OF FATHER,

*James Mitchell*11-BIRTHPLACE OF FATHER
(State or Country),*Balto*

12-MAIDEN NAME OF MOTHER

*Mary Loftus*13-BIRTHPLACE OF MOTHER
(State or Country),*Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mary Loftus*(Address) *2026 Booth St*

15-

SEP - 7 1915

Filed..... 1915

ROBERT KRAUTH

CIVIL DEPT. CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Sept 4, 1915, to Sept 7, 1915*that I saw him alive on *Sept 7, 1915*and that death occurred, on the date stated above, at *3:00* m.

The CAUSE OF DEATH* was as follows:

Chorea cerebri

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *Walter E. ...* M. D.Sept. 7, 1915. (Address) *347 ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Paul Cathedral Ave Sept. 8, 1915

20-UNDERTAKER

ADDRESS

H.C. Wedgfeld 914 Greenmount Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88042

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 31 C88042

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Maryland General Hospital

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs. Feliksa Matuszewski

(Residence in Baltimore: No.

Maryland General Hospital

St.; — yrs., — mos. 6 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

white

5-STATUS.

MARRIED, married.
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

August

1, 1875
(Month) (Day) (Year)

7-AGE.

42

yrs. 1 mos. 7 da.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Housewife
At home9-BIRTHPLACE,
(State or Country).

Russia.

PARENTS.

10-NAME OF FATHER.

Rutkowski

11-BIRTHPLACE OF FATHER
(State or Country).

Poland.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country).

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Tilde Kostkowski

(Address) 13 Cypress St. Curtis Bay

15-

SEP - 8 1915

Filed

191

HARRY O. ANDREWS,

CAPITAL POLICE REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept. 7

(Month)

(Day)

1915
(Year)

17-I HEREBY CERTIFY, That I attended deceased from

Sept. 2, 1915, to Sept. 7, 1915,

that I saw her alive on Sept. 7, 1915,

and that death occurred, on the date stated above, at 6:05 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Distention

(Duration) ... yrs. ... mos. 1 da.

CONTRIBUTORY
(Secondary)

Tubercular Peritonitis

(Duration) unknown ... yrs. ... mos.

(Signed) S. D. Shannon M. D.

191... (Address) Md. Gen. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. 6 da. In the State 10 yrs. ... mos. ... da.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 13 Cypress St. Curtis Bay

19-PLACE OF BURIAL OR REMOVAL.

Holy Cross

DATE OF BURIAL.

Sept 9, 1915

20-UNDERTAKER

William Galkowski

ADDRESS

108 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

C88043

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1018 W. Pratt*)

ST.: *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary E. Raborg

(Residence in Baltimore: No. *1002 W Pratt*)

St.: yrs., *3* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Aug. (Month) *4* (Day), *1914* (Year)

7-AGE,

1 yrs. *1* mos. *2* ds. It LESS than 1 day.
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Va

10-NAME OF FATHER,

B. A. Raborg

11-BIRTHPLACE OF FATHER
(State or Country),

Va

12-MAIDEN NAME OF MOTHER

Amelia Martin

13-BIRTHPLACE OF MOTHER
(State or Country),

Tenn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *B. A. Raborg*

(Address) *1002 W. Pratt st*

15-

SEP 8 1915 HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept (Month) *6* (Day), *1915* (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 3* 1915, to *Sept 6* 1915, that I saw h *er* alive on *Sept 6* 1915, and that death occurred, on the date stated above, at *7:30* m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds. *4*

CONTRIBUTORY
(Secondary)

Bedridden of lungs

(Duration) yrs. mos. ds. *1*

(Signed) *E. H. H. H. H. H.* M. D.

24 21 Fulton (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Catholic Cemetery Sept. 8, 1915

20-UNDERTAKER

ADDRESS

John F. Filds 1202 W. Lombard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88044

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88044

PLACE OF DEATH
CITY OF BALTIMORE: (No. 1468 William St.; 24 WARD)
2-FULL NAME Mary E. Shipley
(Residence in Baltimore: No. 1468 William St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female
4-COLOR OR RACE white
5-SINGLE MARRIED WIDOWED OR DIVORCED married
6-DATE OF BIRTH Unknown, 1 1899
7-AGE 66 yrs. mos. ds. or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
Homemaker

9-BIRTHPLACE (State or country)
Tracy, A. A. Co. Ind.

PARENTS
10-NAME OF FATHER John Ford
11-BIRTHPLACE OF FATHER (State or country) Tracy, A. A. Co. Ind.
12-MAIDEN NAME OF MOTHER Kate Howell
13-BIRTHPLACE OF MOTHER (State or country) Tracy, A. A. Co. Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Root Shipley
(Address) 1468 William St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH September 5, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19, 1915, to Sept 5, 1915, that I saw her alive on Sept 5, 1915, and that death occurred, on the date stated above, at 11:30 a. m.
The CAUSE OF DEATH* was as follows:

chronic nephritis

Contributory (SECONDARY)
(Duration) yrs. mos. ds.

(Signed) Robert G. Schmitt M. D.
Sept 6, 1915 [Address] 1370 A. Charles St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Friendship A. C. R. Sept 8, 1915

20-UNDERTAKER ADDRESS

Mrs. Mahoney 318 Light St.

SEP - 8 1915

HARRY O. ANDREWS

Marital Permit Clerk REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88045

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *540 N. Brin*)

ST. *70* WARD)

2-FULL NAME

Infant of Harry & Bessie Cohen

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

(Residence in Baltimore: No. *540 N. Brin*)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX <i>female</i>	4-COLOR OR RACE <i>white</i>	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH <i>Sept. 7, 1915</i> (Month) (Day) (Year)		
7-AGE yrs. mos. ds. If LESS than 1 day, hrs. or 5 min.?		
8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
9-BIRTHPLACE (State or country) <i>Baltimore City</i>		
PARENTS	10-NAME OF FATHER <i>Harry Cohen</i>	
	11-BIRTHPLACE OF FATHER (State or country) <i>Baltimore Md</i>	
	12-MAIDEN NAME OF MOTHER <i>Bessie Sachs</i>	
	13-BIRTHPLACE OF MOTHER (State or country) <i>Russia.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Cohen

(Address)

540 N. Brin St.

15.

SEP - 8 1915

HARRY O. ANDREWS
Serial Permit 0101

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 7, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from

Sept 7, 1915, to, Sept 7, 1915.

that I saw *her* alive on *Sept 7, 1915.*

and that death occurred, on the date stated above, at *10 P* m.

The CAUSE OF DEATH* was as follows:

Abortion 4 1/2 mos. -

(Duration) yrs. mos. ds

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

M. Bauman Hood

M. D.

Sept 7, 1915.

(Address) *636 N. Gilman St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Mt Cemetery

9/8, 1915

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1019 N. Gilman* ST.;

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Elizabeth Hagner*(Residence in Baltimore: No. *1019 N. Gilman*St.; *15* yrs., .. mos. .. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

Unknown, 1855

(Month)

(Day)

(Year)

7-AGE,

60 yrs. .. mos. .. ds.

If LESS than 1 day,

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Illinois

10-NAME OF FATHER,

Davis

11-BIRTHPLACE OF FATHER (State or Country),

Dont Know

12-MAIDEN NAME OF MOTHER

Dont Know

13-BIRTHPLACE OF MOTHER (State or Country),

Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary A. Bushby*(Address) *311 N. Stricker*

15-SEP - 8 1915

Filed

191

THOMAS O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 8, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 1, 1915*, to *Sept 8, 1915*,that I saw him alive on *Sept 7, 1915*,and that death occurred, on the date stated above, at *7:15* m.

The CAUSE OF DEATH* was as follows:

Malignant Ovarian Cyst

(Duration) .. yrs. .. mos. .. ds.

CONTRIBUTORY (Secondary)

Septic Infection

(Duration) .. yrs. .. mos. .. ds.

(Signed)

J. H. Norwood M. D.101... (Address) *439 N. Fayette St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .. yrs. .. mos. .. ds. In the State .. yrs. .. mos. .. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*not listed**Sept. 10, 1915*

20-UNDERTAKER

ADDRESS

*for fundans, Inc**217 S. Penn*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bellview Apt., ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Bernard J. Gold,(Residence in Baltimore: No. Madison Ave & Bloom Sts, St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX
Male4-COLOR OR RACE,
White,5-SINGLE, Single,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Oct. 12th., 1849.
(Month) (Day) (Year)

7-AGE,

65 yrs. 10 mos. 26 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. retired,(b) General nature of industry, business, or establishment in which employed (or employer). Grocery Merchant

9-BIRTHPLACE,

(State or Country), Frederick Md.,

10-NAME OF FATHER,

Abraham Gold,

11-BIRTHPLACE OF FATHER

(State or Country), Germany,

12-MAIDEN NAME OF MOTHER

Babette Hutzler,

13-BIRTHPLACE OF MOTHER

(State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. Gold(Address) Bellview Apt.

15-

SEP - 8 1915Filed SEP - 8 1915 REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 7th., 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 24, 1915, to Sept 7, 1915,that I saw him alive on Sept 7, 1915,and that death occurred, on the date stated above, at 8A m.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar(Duration)....yrs....mos....5 ds.

CONTRIBUTORY (Secondary)

Cardiac Defect(Signed) Joseph Elgich M. D.Sept 8, 1915 (Address) 1516 Mad. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs....mos....ds. In the Stateyrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Har Sinai

DATE OF BURIAL,

SEP 8, 1915

20-UNDERTAKER

Car & S. Goldstein

ADDRESS

1516 Mad. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88048

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88048

CERTIFICATE OF DEATH

1. PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *1136 Forest St*)

ST. *10* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME *Sylvania Charteris*

(Residence in Baltimore: No. *1136 Forest St*)

St. *40* yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single* (If write the word)

6. DATE OF BIRTH *Unknown, 1888* (Month) (Day) (Year)

7. AGE *about 57* yrs. — mos. — ds. If LESS than 1 day, — hrs. or — min.?

8. OCCUPATION *none* (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Penna.* (State or country)

PARENTS 10. NAME OF FATHER *Geo. N. Charteris* 11. BIRTHPLACE OF FATHER *Penna* (State or country) 12. MAIDEN NAME OF MOTHER *May Ann Long* 13. BIRTHPLACE OF MOTHER *Penna* (State or country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Sarah B. Mickey*

(Address) *1136 Forest St*

15. *SEP - 8 1915* HARRY O. ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept 6, 1915* (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 6, 1915* to *Sept 6, 1915*, that I saw him alive on *Sept 5, 1915*, and that death occurred, on the date stated above, at *7:45* p. m. The CAUSE OF DEATH* was as follows:

Carcinoma of uterus (Operation) (Duration) *2* yrs. — mos. — ds.

Contributory (SECONDARY) (Duration) — yrs. — mos. — ds. (Signed) *G. L. Ramsey* M. D. *Sept 7, 1915* (Address) *1103 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds. Where was disease contracted? If not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Western Cemetery* DATE OF BURIAL *Sept 8, 1915*

20. UNDERTAKER *Joseph To Cook* ADDRESS *1003 Wood Baltimore*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph Hospital* ST.; *12* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME

Mahlon Brown(Residence in Baltimore: No. *1707 Barclay St.*St.; *42* yrs., *6* mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white.

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

single

6-DATE OF BIRTH,

Sept 1, 1873
(Month) (Day) (Year)

7-AGE,

42 yrs. *6* mos. *6* ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer).....

*office work*9-BIRTHPLACE,
(State or Country),*Balto Md*

10-NAME OF FATHER,

*Richard P. Brown*11-BIRTHPLACE OF FATHER
(State or Country),*Md.*

12-MAIDEN NAME OF MOTHER

*Rebecca Slaysman*13-BIRTHPLACE OF MOTHER
(State or Country),*Balto, Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*Mrs. Brown*(Address).....*1019 N. Hall St*

15-SEP - 8 1915

HARRY O. ANDREWS,

Filed.....191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 7, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 26* 1915, to *Sept 7* 1915, that I saw him alive on *Sept 7* 1915, and that death occurred, on the date stated above, at *7:30 A m.*

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Myocarditis.....(Duration).....yrs. *11* mos. *6* ds.CONTRIBUTORY
(Secondary)*Pulmonary Edema*.....(Duration).....yrs. *3* mos. *3* ds.(Signed).....*O. V. Penhardt*.....M. D.*Sept 7, 1915* (Address).....*St Joseph Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. *12* ds. In the State yrs. *42* mos. *6* ds.Where was disease contracted, if not at place of death? *do not know*Former or usual residence *1707 Barclay St.*

19-PLACE OF BURIAL OR REMOVAL,

Greenmount Cemetery

DATE OF BURIAL,

Sept 7, 1915

20-UNDERTAKER

Robt M. Flynn

ADDRESS,

1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88050

C88050

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 104 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs., 2 mos. 19 ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

single

6-DATE OF BIRTH,

June 19, 1915
(Month) (Day) (Year)

7-AGE,

2 19
yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE,
(State or Country),

Balto. Md

PARENTS.

10-NAME OF FATHER,

Wm. H. Gaierty

11-BIRTHPLACE OF FATHER
(State or Country),

Balto., Md.

12-MAIDEN NAME OF MOTHER

Anne Wise

13-BIRTHPLACE OF MOTHER
(State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm. H. Gaierty

(Address)

1025 N. Mount St.

15-

SEP - 8 1915

Filed 191

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 7, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 2, 1915, to about 1915, that I saw him alive on Sept 7, 1915, and that death occurred, on the date stated above, at 99 m. The CAUSE OF DEATH* was as follows:

Death was due to chronic dysentery.
(Duration) 2 years 10 mos. 19 ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. L. Drews M. D.

Sept 7, 1915. (Address) 124 N. Mount St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Peters Cemetery

DATE OF BURIAL,

Sept 8, 1915

20-UNDERTAKER,

H. J. M. G. Flynn

ADDRESS

1422 Light St

CAUSE OF DEATH IN PLAIN TERMS, so that it may be properly understood. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88051

C88051

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *5* WARD)

2-FULL NAME *Earl Stewart*

(Residence in Baltimore: No. *922 E. Balto. St.* St.; yrs. *4* mos. *23* ds.)

REGISTERED No. C. *104*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

April

(Month)

15

(Day)

1915

(Year)

7-AGE

4

mos.

23

ds.

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

home

9-BIRTHPLACE
(State or country)

md. (City)

10-NAME OF FATHER

Wm. Stewart

11-BIRTHPLACE OF FATHER
(State or country)

Iowa

12-MAIDEN NAME OF MOTHER

Label Haskell

13-BIRTHPLACE OF MOTHER
(State or country)

N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. C. Smith

(Address)

Johns Hopkins Hosp

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September

(Month)

7

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *September 4, 1915*, to *September 7, 1915*, that I saw him alive on *September 7, 1915*, and that death occurred, on the date stated above, at *5 p. m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis

Contributory (SECONDARY)

probable malnutrition

(Signed)

W. F. Power

M. D.

Sept 8, 1915 [Address] *Johns Hopkins Hosp*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. *3* mos. *3* ds. In the State... yrs. *4* mos. *23* ds.

Where was disease contracted, If not at place of death? *922 E Balto St*

Former or usual residence *922 E. Balto St*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Carmel Cemetery

Sept 8, 1915

20-UNDERTAKER

ADDRESS

Alfred E. Hallen

221 N Broadway

15-SEP - 8 1915
Filed 191

HARRY O. ANDREWS

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88052

CERTIFICATE OF DEATH.

104

C88052

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. Elizabeth Home* St.:

yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.) *Single*

6-DATE OF BIRTH.

Unknown

(Month)

(Day)

(Year)

7-AGE.

about 3

yrs.

15

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.

(State or Country).

Ind.

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER.

(State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER.

(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

SEP - 8 1915

191

HARVEY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 22, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Aug 19, 1915, to Aug 22, 1915,*that I saw him alive on *Aug 22, 1915,*and that death occurred, on the date stated above, at *93.09* in.

The CAUSE OF DEATH* was as follows:

*Intestinal Decomposition**About*

(Duration).....yrs.....!..mos.....ds.

CONTRIBUTORY

(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Edward P. Smith* M. D.Sept 6, 1915 (Address) *Mercy Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? *St. Elizabeth Home*Former or usual residence *St. Elizabeth Home*

19-PLACE OF BURIAL OR REMOVAL.

COLLEGE OF P. & S.

DATE OF BURIAL

SEP 7 1915

20-UNDERTAKER

Comptroller Health,

ADDRESS

Per. Wm. H. Woodall.

CAUSE OF DEATH in plain terms so that it may be properly translated. See instructions on back of certificate.

C88053

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88053

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital

ST.

10

WARD)

REGISTERED NO. C

2-FULL NAME

Edna Powell

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

907 Hillman

St.: 16 yrs., — mos., — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH.

Unknown, 18.9.99

(Month)

(Day)

(Year)

7-AGE,

16

yrs. mos. da.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE,

(State or Country),

Baltimore, Maryland

PARENTS.

10-NAME OF FATHER,

Gaster Powell Porter

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore City

12-MAIDEN NAME OF MOTHER

Bertie Anderson

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....

Wm. L. Miller M.D.

(Address)....

Johns Hopkins Hospital

15-

SEP - 8 1915

HARRY Q. ANDREWS

Filed.....

191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 6, 1915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

August 27, 1915, to September 6, 1915,

that I saw her alive on daily visits from August 1915,

and that death occurred, on the date stated above, at 7:25 p.m.

The CAUSE OF DEATH* was as follows:

Septicaemia, Puerperal

(Duration)..... yrs. mos. da.

CONTRIBUTORY (Secondary)

Syphilis & Tuberculosis

(Duration)..... yrs. mos. da.

(Signed)..... Wm. L. Miller..... M. D.

Sept. 6, 1915. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. da. In the State..... 16 yrs. mos. da.

Where was disease contracted, 907 Hillman St.

if not at place of death?

Former or usual residence

907 Hillman St

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Laurel Glen

Sept. 8 1915.

20-UNDERTAKER

ADDRESS

John W. Henderson

317 Calverton

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

946 S. Eutan

ST.

21

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Baby Harris

(Residence in Baltimore: No.

946 S. Eutan

St.; 0 yrs., 0 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Black

5-SINGLE,

MARRIED, SINGLE,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Aug

31.,

1915

(Month)

(Day)

(Year)

7-AGE,

0 yrs., 0 mos., 0 ds.

If LESS than 1 day,

0 hrs. or 0 min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Maryland (City)

10-NAME OF FATHER,

Edward Nicholson

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Rose Harris

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP - 8 1915

Filed

191

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

4.,

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from 8-31 1915, to 9-4 1915, that I saw him alive on 9-4 1915, and that death occurred, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows:

Congenital defect

(Duration) 2 yrs., 0 mos., 0 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs., mos., ds.

(Signed) P. L. Reish M. D.

9-6, 1915. (Address) University Hall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,
COLLEGE OF P. & S.

DATE OF BURIAL,

SEP. 7, 1915

20-UNDERTAKER
Health.

ADDRESS

important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88055

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

C88055

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Hebrew Hospital*)

ST.: *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Celia J. Dapkowski*

(Residence in Baltimore: No. *1119 S. Binnier St*)

St.: yrs. *8* mos. *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *female* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6-DATE OF BIRTH *Dec 25, 1914*
(Month) (Day) (Year)

7-AGE *8* yrs. *11* mos. *11* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION *none*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore*

10-NAME OF FATHER *Anthony Dapkowski*

11-BIRTHPLACE OF FATHER (State or country) *Poland*

12-MAIDEN NAME OF MOTHER *Mary Augustina*

13-BIRTHPLACE OF MOTHER (State or country) *Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Anthony Dapkowski*

(Address) *1119 S. Binnier*

SEP - 8 1915

Filed 191

HARRY O. ANDREWS,

MUNICIPAL HEALTH CLERK

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *September 6, 1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from *Sept. 2*, 1915, to *Sept. 6*, 1915, that I saw her alive on *Sept. 6*, 1915, and that death occurred, on the date stated above, at *10.10 p.m.* The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(Duration) yrs. *4* mos. *4* ds

Contributory (SECONDARY)

(Signed) *M. B. Levin* M. D. *Sept. 6, 1915* (Address) *Hebrew Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *4* yrs. *4* mos. *11* ds. In the State *8* yrs. *11* mos. *11* ds. Where was disease contracted, *1119 S. Binnier St.* If not at place of death? Former or usual residence *1119 S. Binnier St.*

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Stanislaus Cem. *Sept 8, 1915*

20-UNDERTAKER ADDRESS

Stephen J. Tralowski *1019 S. Binnier St.*

Avy

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88056

C88056

170

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

443 Pinkney Place

ST.

12

WARD

2-FULL NAME

Virginia D. Bishop

(Residence in Baltimore: No.

443 Pinkney Place

ST.

Life time

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widowed

6-DATE OF BIRTH

Dec 20, 1858

7-AGE

56 yrs. 8 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Baltimore

10-NAME OF FATHER

Ger. Seithuser

11-BIRTHPLACE OF FATHER (State or country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Carter

(Address)

443 Pinkney Place

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 7, 1915

17- I HEREBY CERTIFY, That I attended deceased from

July 7, 1915, to, Sept 7, 1915,

that I saw her alive on Sept 7, 1915,

and that death occurred, on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease,
Chronic Interstitial Nephritis.

(Duration) 5 yrs. mos. ds.

Contributory (SECONDARY)

Toxemia

(Duration) yrs. mos. ds.

(Signed),

Rough Forsythe

M. D.

, 191

(Address)

421 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount Olivet Cemetery

Sept 7, 1915

20-UNDERTAKER

ADDRESS

Wm. Henry Lutz

1007 N. Bond

15- SEP - 8 1915

HARRY O. ANDREWS,

Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 E. Lafayette St. 17 WARD)2-FULL NAME Wm. W. Wittman(Residence in Baltimore: No. 324 E. Lafayette

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

July 6, 1839
(Month) (Day) (Year)

7-AGE,

76 yrs. 2 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Merchant
Gen. Mdce.

9-BIRTHPLACE,

(State or Country), Md.

10-NAME OF FATHER,

John W. Wittman

11-BIRTHPLACE OF FATHER

(State or Country), Germany

12-MAIDEN NAME OF MOTHER

Rose Singer

13-BIRTHPLACE OF MOTHER

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Grace Boydon(Address) 324 E. Lafayette St.

15-

SEP - 8 1915

Filed

191

ROBERT

KRAUTER

BALTIMORE CLERK

Registrar.

Munoz 1801 Guilford Ave

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 7, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1915, to Sept 7 1915, that I saw him alive on Sept 6 1915, and that death occurred, on the date stated above, at 2:30 p.m.

THE CAUSE OF DEATH* was as follows:

Infirmities 7 old age
hastened by a fall from a
car about 5 or 6 weeks ago
(Duration) 5 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Signed) E. A. Munoz M. D.
9/7 1915. (Address) 1801 Guilford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western

DATE OF BURIAL,

Sept 9, 1915

20-UNDERTAKER

Wm. Wolf

ADDRESS

324 E. North
St.

important. See instructions on back of certificate.

C88058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 C88058
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1038 N. Stricker

ST.: 16 WARD)

FULL NAME

William Oliver Parlett

(Residence in Baltimore: No. 1038 N. Stricker

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

St.: Life yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 30th, 1836
(Month) (Day) (Year)

7-AGE,

79 yrs. 2 mos. 7 ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Bricklayer & Builder

9-BIRTHPLACE,
(State or Country),

Baltimore City - Maryland

10-NAME OF FATHER,

John Parlett

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore Co.

12-MAIDEN NAME OF MOTHER

Ellen Elizabeth Buck

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ... *Mattie M. Parlett*(Address) ... *1038 N. Stricker St.*

15-

SEP - 8 1915

ROBERT KRAUTH

FIND ... 1915 ...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 7th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Aug 18 1915, to Sept 7 1915,
that I saw him alive on Sept 7 1915,
and that death occurred, on the date stated above, at 11:20 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 25 yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)

(Duration) — yrs. — mos. 21 ds.

(Signed) O. N. Drwall M. D.

9/8/15, 1915 (Address) 1817 N. Fullman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Parlett Cemetery Sept. 10, 1915

20-UNDERTAKER

ADDRESS

Wm Cook 502 E. North

important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

88059 HEALTH DEPARTMENT--CITY OF BALTIMORE
CERTIFICATE OF DEATH
1 PLACE OF DEATH
CITY OF BALTIMORE: (No. *Johns Hopkins Hospital*) WARD
2-FULL NAME *Engelina Anabaz*
(Residence in Baltimore: No. *Johns Hopkins Hospital* St.; yrs. *17* mos. *16* ds.)

PERSONAL AND STATISTICAL PARTICULARS
3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Sing.*
6-DATE OF BIRTH *Sept. 22 1914*
7-AGE *11* yrs. *16* mos. *16* ds. or min.?
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) *None.*
9-BIRTHPLACE (State or country) *md.*
PARENTS
10-NAME OF FATHER *Stev. Anabaz.*
11-BIRTHPLACE OF FATHER (State or country) *Poland*
12-MAIDEN NAME OF MOTHER *Olenschuk.*
13-BIRTHPLACE OF MOTHER (State or country) *Poland.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *P. Phelps.*
(Address) *Johns Hopkins Hosp.*

15- *SEP - 8 1915*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH
16-DATE OF DEATH *Sept. 7 1915*
17-I HEREBY CERTIFY, That I attended deceased from *Sept. 7 1915*, to *Sept. 7 1915*, that I saw her alive on *Sept. 7 1915*, and that death occurred, on the date stated above, at *3:42* p.m.
The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion with acidosis
Contributory (SECONDARY)
(Signed) *E. F. Powers*
Sept. 5 1915 [Address] *Johns Hopkins Hosp.*
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death *1* yrs. *1* mos. *1* ds. State *1* yrs. *1* mos. *1* ds.
Where was disease contracted, if not at place of death?
Former or usual residence *188 Cypress* *6011 Bay md*

19-PLACE OF BURIAL OR REMOVAL *Holy Cross* DATE OF BURIAL *Sept 9 1915*
20-UNDERTAKER *William Fialkowski* ADDRESS *1618 Eastern Ave.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88060

CERTIFICATE OF DEATH.

66 C88060

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1408 Hanover* ST.; *23* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1408 Hanover St.* St.; *79* yrs., *0* mos., *0* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

June 6, 1836
(Month) (Day) (Year)

7-AGE

*79 yrs., 2 mos., 0 ds.*If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Nurse*

9-BIRTHPLACE, (State or Country),

Penn.

10-NAME OF FATHER,

Robt Bruce McGurdy

11-BIRTHPLACE OF FATHER (State or Country),

Scotland

12-MAIDEN NAME OF MOTHER

Mary E Snyder

13-BIRTHPLACE OF MOTHER (State or Country),

Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

ROBERT J. KRAUTER,

Regist. P. 8-1915 191. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

September 6, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 9, 1915*, to *Sept 6, 1915*, that I saw her alive on *Sept 3, 1915*, and that death occurred, on the date stated above, at *1045 p.m.*

The CAUSE OF DEATH* was as follows:

Paralysis
Left Hemiplegia(Duration) *5* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

(Duration) *2* yrs. *0* mos. *0* ds.(Signed) *Chas E. ...* M. D.*Sept 8, 1915* (Address) *1021 ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *...* yrs. *...* mos. *...* ds. In the State *...* yrs. *...* mos. *...* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London ...

DATE OF BURIAL

Apr. 9, 1916

20-UNDERTAKER

William ...

ADDRESS

North ...

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 W. Lombard ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1723 W. Lombard St.; 45 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Married

6-DATE OF BIRTH,

unknown, 1.....
(Month) (Day) (Year)

7-AGE,

76

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
Teacher9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

SEP - 8 1915

ROBERT A. KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 7, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 2 1915, to Sept 7 1915, that I saw him alive on Sept 7 1915, and that death occurred, on the date stated above, at 11:58 m.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) 10 yrs., mos., ds.CONTRIBUTORY
(Secondary)(Duration) 10 yrs., mos., ds.(Signed) E. O. O'Connell M. D.Sept 8, 1915. (Address) 24 W. Fulton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Woodlawn Cemetery Sept 10 1915

20-UNDERTAKER

ADDRESS

John J. Cowan 901 Hollins St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *903 W Lombard*)ST.: *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *903 W Lombard*)St.; *20* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

*Married**Widowed*

(Write the word.)

6-DATE OF BIRTH,

unknown, *1* (Month) (Day) (Year)

7-AGE,

44

If LESS than 1 day,

yrs. mos. ds. hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Washington D.C.

10-NAME OF FATHER,

John Pinner

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Catherine Laguan

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edward Blair

(Address)

903 W Lombard

15-

Filed

SEP - 8 1915

191

ROBERT

KRAUTER,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 7, *1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 191*4*, to *Sept 7* 191*5*,that I saw him alive on *Sept 6* 191*5*,and that death occurred, on the date stated above, at *8 A.* m.

The CAUSE OF DEATH* was as follows:

Anemia(Duration) yrs. mos. ds. *5*

CONTRIBUTORY (Secondary)

Chronic Mitral Regurgitation(Duration) yrs. mos. ds. *2*(Signed) *E. DeVolubian* M. D.*Sept 8*, 191*5*. (Address) *24 W Fullinwider*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Catholic Cemetery**Sept 9*, 191*5*

20-UNDERTAKER

ADDRESS

*John J. Cowan & Son**901 Hollins*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *11* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *130 W. Hoffman* ST. *11* yrs., *11* mos., *21* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *Black* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH, *March* *18*, *1870*
(Month) (Day) (Year)

7-AGE, *45* yrs., *5* mos., *21* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Virginia*

10-NAME OF FATHER, *Tom Jones*

11-BIRTHPLACE OF FATHER (State or Country), *Va*

12-MAIDEN NAME OF MOTHER *Bessie Taylor*

13-BIRTHPLACE OF MOTHER (State or Country), *Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *G. J. Smith*

(Address) *Johns Hopkins Hosp*

15- *SEP - 9 1915*

Filed *SEP - 9 1915*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *September* *8*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *August 25 1915*, to *September 8 1915*, that I saw her alive on *September 8 1915*, and that death occurred, on the date stated above, at *11:5 am*.

The CAUSE OF DEATH* was as follows:

Caecum cancer Superior mesenteric artery Chronic nephritis

(Duration) *1* yrs., *11* mos., *21* ds.

CONTRIBUTORY (Secondary) *Operation shock*

(Duration) *1* yrs., *11* mos., *21* ds.

(Signed) *A. D. McCreary* M. D.

Sept 8, 1915 (Address) *Johns Hopkins Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *14* yrs., *11* mos., *21* ds. In the *11* yrs., *11* mos., *21* ds.

Where was disease contracted, if not at place of death? *-*

Former or usual residence *130 W Hoffman St*

19-PLACE OF BURIAL OR REMOVAL, *Prosser's*

DATE OF BURIAL, *Sept 9, 1915*

20-UNDERTAKER *George H. Holland*

ADDRESS *517 Probat*

C88064

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88064

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 526 Lambert street, St. 17 WARD)

2-FULL NAME

Alfred R. Sewell,

(Residence in Baltimore: No.

526 Lambert street,

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male,

4-COLOR OR RACE,

Colored,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single,

6-DATE OF BIRTH,

July 15th, 1914.

7-AGE,

1 yrs. 1 mos. 23 ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

Randolph Sewell,

11-BIRTHPLACE OF FATHER (State or Country),

Maryland,

12-MAIDEN NAME OF MOTHER

Dora Snowden,

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Sewell, mother,

(Address) 526 Lambert street.

15-

Filed

SEP - 9 1915

191

HARRY O. ANDREWS,

Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 7th, 1915.

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

...inquiry and that said deceased came to his death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubercula pulmonum et Hydrocephalus tuberculosus,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frederick H. Campbell, M. D. (Coroner.)

Sept. 8, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Auburn

DATE OF BURIAL,

Sept. 9, 1915

20-UNDERTAKER

Samuel T. Homely

ADDRESS,

578 N. Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88065

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1536 Pennsylvania ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1536 Pennsylvania St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)Single

6-DATE OF BIRTH,

Unknown 1901
(Month) (Day) (Year)

7-AGE,

14 yrs., — mos., — ds.If LESS than 1 day,
— hrs. or — min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business, or establishment in which
employed (or employer).none9-BIRTHPLACE,
(State or Country),MD

PARENTS.

10-NAME OF
FATHER,Henry Fenzel11-BIRTHPLACE
OF FATHER
(State or Country),MD12-MAIDEN NAME
OF MOTHERElizabeth Kregenhoff13-BIRTHPLACE
OF MOTHER
(State or Country),MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Fenzel(Address) 1536 Pennsylvania St.

15-

Filed: SEP - 9 1915 1915 HARRY O. ANDREWS,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 7, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Sept 4 1915, to Sept 7 1915,
that I saw him alive on Sept 6 1915,
and that death occurred, on the date stated above, at 3.0 m.The CAUSE OF DEATH* was as follows: acute
systemic Septicemia
(Necrotic)
(Duration) — yrs., — mos., — ds.CONTRIBUTORY
(Secondary)(Duration) — yrs., — mos., — ds.
(Signed) Chas. J. Cantor M. D.
Sept 7 1915 (Address) 48 Moskowitz*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDE.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Redeemer Sept 10, 1915.

20-UNDERTAKER.

ADDRESS

M. Mahoney 5006 Lafayette

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf't Asy.* ST.: *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary Turner(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: *14* yrs. *9* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

December 6th, 1914
(Month) (Day) (Year)

7-AGE,

9 mos. 1 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

SEP - 9 1915.

HARRY O. ANDERSON

Filed

191

Baptist Board of

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 7th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 2nd 1915, to *Sept 7th 1915*,that I saw her alive on *Sept 7th 1915*,and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

Gastro-enteritis(Duration) *5* yrs. *5* mos. *5* ds.

CONTRIBUTORY

(Secondary)

M. abruption(Duration) *2* yrs. *2* mos. *2* ds.(Signed) *J. L. Smith* M. D.*Sept. 7, 1915* (Address) *1223 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *9* yrs. *9* mos. *1* ds. In the State *9* yrs. *9* mos. *1* ds.Where was disease contracted, if not at place of death, *St. Vincent's Inf't Asylum*Former or usual residence *St. Vincent's Inf't Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral Cem**Sept. 10 1915*

20-UNDERTAKER

ADDRESS

*M. Fahy & Sons**606 Lafayette Ave*

important. See instructions on back of certificate.

C88067

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

C88067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Vincent's Infy Asy. St. 14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Martina Nelson(Residence in Baltimore: No. *St. Vincent's Infy Asylum* St.; yrs. *1* mos. *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Single

6-DATE OF BIRTH.

July 9th, 1915
(Month) (Day) (Year)

7-AGE.

*1 mos. 27 ds.*If LESS than 1 day.
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*

9-BIRTHPLACE, (State or Country),

Maryland
Unknown

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

Filed *SEP 9 1915*

HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 6, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 1st* 1915, to *Sept 6th* 1915, that I saw her alive on *Sept 6th* 1915, and that death occurred, on the date stated above, at *11:00 p. m.*

The CAUSE OF DEATH* was as follows:

Malnutrition(Duration) *1 mos. 27 ds.*

CONTRIBUTORY (Secondary)

(Duration) *1 mos. 27 ds.*(Signed) *John S. French, M. D.**Sept 7, 1915* (Address) *1213 N. Carolina St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *27* ds. In the State yrs. *1* mos. *27* ds.Where was disease contracted, if not at place of death *St. Vincent's Infy Asylum*Former or usual residence *St. Vincent's Infy Asylum*

19-PLACE OF BURIAL OR REMOVAL.

Cathedral Cem

DATE OF BURIAL.

Sept. 10, 1915

20-UNDERTAKER

M. Fahy & Sons

ADDRESS

606 Lafayette

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88068

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C88068

PLACE OF DEATH

CITY OF BALTIMORE (No. *2417 Jefferson*)

ST.:

WARD)

REGISTERED NO. C

FULL NAME

Amelia M Ott

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *2417 Jefferson*)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married

WIDOW,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

May 18th, 1857
(Month) (Day) (Year)

7-AGE,

58 yrs. *13* mos. *20* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

Housewife

9-BIRTHPLACE,

(State or Country),

Ind

10-NAME OF FATHER,

Lewis Knapp

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Amelia Vinick

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Conrad Ott

(Address).....

2417 Jefferson St

15-

SEP - 9 1915

HARRY O. ANDREWS,

191.....*121*.....*Peralt*.....*Alar*.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 7th, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*.....
(Inquest, au-

Inquest.....and that said deceased came to *Death*.....
topay or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull (Accident)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Stairway.....(Duration).....yrs.....mos.....ds.

(Signed).....*E. L. H. Russell*.....M. D.

Sept 7th, 1915.....(Address).....*423 X 1st St*.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place.....In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery.....*Sept 10th, 1915*

20-UNDERTAKER

ADDRESS

Christian Miller.....*2517 Jefferson St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88069

120 C88069

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *316 East 20th* ST.; *12th* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *316 East 20th* St. *Life* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH

June 16, 1855
(Month) (Day) (Year)

7-AGE

60 yrs. *1* mos. *22* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Carpenter*9-BIRTHPLACE,
(State or Country),*Md (Baltimore City)*

10-NAME OF FATHER

*Martin Beadenoff*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Emily Turner*13-BIRTHPLACE OF MOTHER
(State or Country),*Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chas. Beadenoff
316 E 20th St

SEP - 9 1915

Filed....., 191.....

191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 7, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 2nd* 1915, to *Sept 7* 1915, that I saw him alive on *Sept 7* 1915, and that death occurred, on the date stated above, at *1 a* m.

The CAUSE OF DEATH* was as follows:

Ends - myocarditis
Intermittent reports(Duration) *1* yrs. *6* mos. *1* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. *6* mos. *1* ds.(Signed) *Jas. G. Fisher* M. D.*Sept 8* 1915. (Address) *1514 Madison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Druid Ridge Cem.

DATE OF BURIAL,

Sept 9th 1915.

20-UNDERTAKER

H. Sander House

ADDRESS

1710 Fleet St.

important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88070

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

C88070

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 16 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. 41 yrs. 29 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-STATUS

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Aug 8, 1874

7-AGE

41 yrs. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

Chief Adjuster

(b) General nature of industry, business, or establishment in which employed (or employer)

Wm. L. Locke & Co.

9-BIRTHPLACE

(State or country)

Balto Md.

10-NAME OF FATHER

Wm. Locke Bourne

11-BIRTHPLACE OF FATHER

(State or country)

Balbert Co Md.

12-MAIDEN NAME OF MOTHER

Alice E. Berry

13-BIRTHPLACE OF MOTHER

(State or country)

Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Denny Bourne
2944 Overman Ave

15-SEP - 9 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 7, 1915

17-I HEREBY CERTIFY, That I attended deceased from

May 1, 1915, to Sept 7, 1915.

that I saw him alive on Sept 7, 1915.

and that death occurred, on the date stated above, at 7.00 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Contributory (SECONDARY)

Ephraim

(Signed)

9/8, 1915 (Address) 2571 E. Consta

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

Sept 10, 1915

20-UNDERTAKER

Vertram

ADDRESS

1723 N. Liberty Ave

C88071

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88071

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1117 North Charles.

ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

2-FULL NAME

Mary Jane Bowie

1117 North Charles

(Residence in Baltimore: No.

St. ~ yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-STATUS *Widowed*
 6-DATE OF BIRTH *March 19th, 1841*
 (Month) (Day) (Year)

7-AGE *74* yrs. *5* mos. *11* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION *House wife*
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Montgomery, Alabama.*

10-NAME OF FATHER *Mundock M. Coz.*

11-BIRTHPLACE OF FATHER (State or country) *Pestland*

12-MAIDEN NAME OF MOTHER *Caroline Boyman*

13-BIRTHPLACE OF MOTHER (State or country) *Alabama.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John R. Bowie
 (Address) *Washington D.C.*

15 SEP - 9 1915

Filed

191

ROBERT J. BRAUTER,
 Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *September 9th, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *September 6th, 1915* to *September 9th, 1915*, that I saw him alive on *September 9th, 1915*, and that death occurred, on the date stated above, at *9:40 a.m.*
 The CAUSE OF DEATH* was as follows:

*Intestinal Obstruction
 Strangulated Hernia*

Contributory (SECONDARY)

(Signed) *Edgar Shirley Perkins* M.D.
Sept 9, 1915 (Address) *Rocky Mount*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted?
 If not at place of death?
 Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Washington D.C.

DATE OF BURIAL

Sept 10, 1915

20-UNDERTAKER

Joe Brook

ADDRESS

1003 St. Baldo St

16. If-Every item of information shown the cemetery supplied. Not shown be listed EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88072 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 C88072
REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *13* WARD)2-FULL NAME *Catherine Bradley*(Residence in Baltimore: No. *2014 Plymouth an* St.: yrs., *6* mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white

5-SINGLE,

Single~~MARRIED,~~~~WIDOWED,~~~~OR DIVORCED,~~

(Write the word.)

6-DATE OF BIRTH,

March *13*, *1915*
(Month) (Day) (Year)

7-AGE,

5 *26* ds.
yrs. mon. ds.If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*child*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

Silbert Bradley

11-BIRTHPLACE OF FATHER

(State or Country),

va

12-MAIDEN NAME OF MOTHER

Bessie Cameron

13-BIRTHPLACE OF MOTHER

(State or Country),

va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward P. Smith*(Address) *Mercy Hospital*

15-

*ROBERT . KRAUTER**SEP 9 1915* *191* *BALTIMORE* *CLERK*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 8, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 3* *1915* to *Sept 8* *1915*, that I saw her alive on *Sept 8* *1915*, and that death occurred, on the date stated above, at *10.20 P.m.*

The CAUSE OF DEATH* was as follows:

Alimentary Intoxication(Duration)..... yrs..... mos. *10* ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *Edward P. Smith* M. D.*Sept. 9*, *1915*. (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos. *5* ds. In the State..... yrs. *6* mos. *1915* ds.Where was disease contracted, if not at place of death? *Wich Wilson Sanatorium*Former or usual residence *2014 Plymouth an*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Marys Hamfden *Apr. 10, 1915*

20-UNDER-TAKER

ADDRESS

Chenoweth Son *Chestnut*

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Mill Race Rd ST.; 13 WARD)2-FULL NAME Willie E Burke(Residence in Baltimore: No. 1504 Mill Race Rd St.; 4 yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Sept 14, 1871
(Month) (Day) (Year)

7-AGE,

43 yrs. 11 mos. 26 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

Housewife9-BIRTHPLACE,
(State or Country),Va.

10-NAME OF FATHER,

Hiram Glen11-BIRTHPLACE OF FATHER
(State or Country),Va.

12-MAIDEN NAME OF MOTHER

Sadie Baughen13-BIRTHPLACE OF MOTHER
(State or Country),Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James F. Burke(Address) 1304 Mill Race Rd

15-

Filed SEP - 9 1915 ROBERT KRAUTH
191 Public Health Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 9, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Sept. 4 1915, to Sept. 9 1915,
that I saw her alive on Sept 8 1915,
and that death occurred, on the date stated above, at 3209.
The CAUSE OF DEATH* was as follows:Pneumonia(Duration) yrs. mos. ds.
CONTRIBUTORY Exposure to cold
(Secondary)(Duration) yrs. mos. ds.
(Signed) C. F. J. Coughlin M. D.
10/10, 1915 (Address) 3201 Roland St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

McGahysville Va Sept. 10, 1915

20-UNDERTAKER

ADDRESS

Chenoweth & Son Chestnut

TION is very important. See instructions on back of certificate.

C88075

Granderson 10 Jarvis
HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 C88075

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 754 Columbus Ave. ST. 21) WARD)

2-FULL NAME

Granderson S. Jarvis

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 754 Columbia Ave. St. 19 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male	4-COLOR OR RACE white	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married
6-DATE OF BIRTH Sept 28 1825 (Month) (Day) (Year)		
7-AGE 89 yrs 11 mos 12 ds. or min.? If LESS than 1 day, hrs.		
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Salesman Shoes		
9-BIRTHPLACE (State or country) Wm.		

PARENTS	10-NAME OF FATHER not known
	11-BIRTHPLACE OF FATHER (State or country) not known
	12-MAIDEN NAME OF MOTHER not known
	13-BIRTHPLACE OF MOTHER (State or country) not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Amelia H. Jarvis
(Address) 754 Columbia Ave.

15-

SEP - 9 1915

ROBERT KRAUTER,
Burial Permit Clerk,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 8 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 31 1915, to Sept 8 1915, that I saw him alive on Sept 7 1915, and that death occurred, on the date stated above, at 2:45 a.m. The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
coming partly from paralysis of
legs about 7 yrs mos. ds.
Contributory Paralysis of bladder & rectum
(SECONDARY)
(Duration) yrs 2 mos. ds.
(Signed) N. E. Kniff M. D.
Sept 9 1915 [Address] 102 W. Lenoir

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

Sept 10 1915

20-UNDERTAKER

Joe. B. Cook

ADDRESS

1003 Wood Baltimore

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1120 Hollins St

ST.

WARD)

2-FULL NAME

Christian Kaufman

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 18.)

(Residence in Baltimore: No.

1120 Hollins

St.; 71 yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

widower

6-DATE OF BIRTH

Feb

2

1894

(Month)

(Day)

(Year)

7-AGE

71

7

5

ds.

or

min?

If LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer)

Proprietor

9-BIRTHPLACE
(State or country)

Beveria - Germany

10-NAME OF FATHER

John J. Kaufman

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Lena Resler

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David Kaufman

(Address)

1120 Hollins St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept

7

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1915, to September 7, 1915, that I saw h..... alive on September 1, 1915, and that death occurred, on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration)

yrs.

6

mos.

ds.

Contributory
(SECONDARY)

Asthma

(Duration)

yrs.

6

mos.

ds.

(Signed)

J. B. Brown

M. D.

Sept 7, 1915

[Address]

120 E. Lombard St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

Sept 10

1915

20-UNDERTAKER

J. B. Cook

ADDRESS

1003 N. B. St.

SEP - 9 1915

ROBERT

KRAUTER

Filed

191

Burial Park

REGISTRAR

TION is very important. See instructions on back of certificate.

88077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *1*)

2-FULL NAME

(Residence in Baltimore: No. *1*)ST. *4*

WARD

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.) *1 1/2 day*

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

March

(Month)

2

(Day)

1859

(Year)

7-AGE

*58**6*

yrs.

7

mos.

7

da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE

(State or Country),

Germany

10-NAME OF FATHER

John Aitt

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lena Aitt

(Address)

Roslyn Md.

15-

SEP - 9 1915

Filed

191

ROBERT KRAUTER,
Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

September

(Month)

9

(Day)

1915

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

Inquest

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

*Accident - Fracture pelvis
(2nd curve) due to fall down
barn steps*(Duration).....yrs.....mos.*1 1/2*ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

W. H. Chamberlain M. D.

(Coroner.)

Sept. 9

1915

(Address)

18 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death.....yrs.....mos.*1 1/2*da.

In the

8 yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

Roslyn Md.

19-PLACE OF BURIAL OR REMOVAL

Holy Cross Cem.

DATE OF BURIAL

Sept. 11, 1915

20-UNDERTAKER

Harry W. Ehlen

ADDRESS

1944 W. North Ave.

important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C88078

CERTIFICATE OF DEATH

X 136

C88078

PLACE OF DEATH

Sophia W. Hoene

REGISTERED NO. C

CITY OF BALTIMORE (No.

Hebrew Hospital

ST.

WARD)

FULL NAME

Sophia W. Hoene

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

Hebrew Hospital

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

white

SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word)

DATE OF BIRTH

February 11, 1879

AGE

36 yrs. 6 mos. 28 ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

BIRTHPLACE

(State or country)

Baltimore Co. Md.

NAME OF FATHER

Charles W. Maidner

PARENTS

BIRTHPLACE OF FATHER
(State or country)

Baltimore Co. Md.

MAIDEN NAME OF MOTHER

Sophia List

BIRTHPLACE OF MOTHER
(State or country)

Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry E. Hoene

(Address)

Windsor Mill Road

15

SEP 10 1915

HARRY O. ANDREWS,

Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Sept. 9, 1915

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 5, 1915, to Sept. 9, 1915.

that I saw her alive on *Sept. 9, 1915.*

and that death occurred, on the date stated above, at *10²⁹ a.m.*

The CAUSE OF DEATH* was as follows:

Abdominal Cesarean Section

Contributory (SECONDARY)

General Peritonitis

(Signed)

M. B. Levine

M. D.

Sept. 9, 1915 (Address) *Hebrew Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State *36 yrs. 6 mos. 28 ds.*

Where was disease contracted, *Hebrew Hospital*

If not at place of death? Former or usual residence *Windsor Mills Road Baltimore*

19. PLACE OF BURIAL OR REMOVAL

Lorraine Cemetery

DATE OF BURIAL

Sept 10, 1915

20. UNDERTAKER

Geo W Little

ADDRESS

531 Fremont Ave

C88079

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88079

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *609 Pierce* St.; *17* WARD)2-FULL NAME *Mary E. McRoy*(Residence in Baltimore: No. *609 Pierce* St.; *12* yrs., mos. ds)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Colored*5-SINGLE, *Widowed*MARRIED, *Widowed*OR DIVORCED, *Widowed*

(Write the word.)

6-DATE OF BIRTH, *Unknown*, 18*58*

(Month)

(Day)

(Year)

7-AGE, *57*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *House work*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Ind*10-NAME OF FATHER, *Frank Emery*11-BIRTHPLACE OF FATHER, (State or Country), *Ind*12-MAIDEN NAME OF MOTHER, *Charity Brooks*13-BIRTHPLACE OF MOTHER, (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Charity Garrett*(Address) *7710 Wallace St.*

15-

FILED

SEP 10 1915

HARRY O. ANDREWS,

Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 8th*, 191*5*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 30* 191*5*, to *Sept 7* 191*5*, that I saw her alive on *Sept 7* 191*5*, and that death occurred, on the date stated above, at *2:25* p. m.

The CAUSE OF DEATH* was as follows:

*Mitral Insufficiency*CONTRIBUTORY (Secondary) *Exhaustion*(Signed) *J. D. Hughes*

M. D.

191*5*(Address) *1483 27th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *W. Auburn Cemetery*DATE OF BURIAL, *Sept. 10 1915*20-UNDERTAKER, *Robert A. Elliott*ADDRESS, *806 Rogers*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88080

104 C88080

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2024 Aliceanna

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

Joseph Jablonski

(Residence in Baltimore: No. 2024 Aliceanna

St.; yrs. 6 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Single

6-DATE OF BIRTH.

Feb

28

1915

(Month)

(Day)

(Year)

7-AGE.

5

mos.

11

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE,
(State or Country).

Baltimore, Md.

10-NAME OF FATHER.

Michael Jablonski

11-BIRTHPLACE OF FATHER
(State or Country).

Baltimore

12-MAIDEN NAME OF MOTHER

Mary Sedowska

13-BIRTHPLACE OF MOTHER
(State or Country).

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jablonski

(Address) 2024 Aliceanna

15-SEP 10 1915

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept

9

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 5 1915 to Sept 9 1915

that I saw him alive on Sept 9 1915

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Enteric fever

(Duration)..... yrs..... mos. 1 ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) M. D.

Sept 9, 1915. (Address) 1615 B. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

Sept 10, 1915

20-UNDERTAKER

William G. Gelfand

ADDRESS

1615 Eastern ave.

C88081

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

237 Pool Street

ST.

WARD)

2-FULL NAME

Charles E. Burrier

237 Pool Street

(Residence in Baltimore: No.

St.; - yrs. - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

Nov. 6

18 41

(Month)

(Day)

(Year)

7-AGE

73

10

2

If LESS than

1 day,

hrs.,

ds. or

min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Belt Maker

9-BIRTHPLACE

(State or country)

Maryland

10-NAME OF FATHER

Soloman Burrier

11-BIRTHPLACE OF FATHER
(State or country)

Frederick, Md.

12-MAIDEN NAME OF MOTHER

Elizabeth Link

13-BIRTHPLACE OF MOTHER
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Mr. George Burrier

(Informant)

4136 Falls Road

(Address)

15-

SEP 10 1915

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 15, 1915, to, Sept 8, 1915,

that I saw him alive on Sept 8, 1915,

and that death occurred, on the date stated above, at 11:30m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia
of Bright's DiseaseContributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

Sept 8, 1915 (Address) 3847 Roland

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

In the

ds. State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

David Ridge

Sept 10, 1915

20-UNDERTAKER

A.S. Marshall

ADDRESS

3339

Falls Road

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* St.; *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *University Hospital* St.; — yrs., — mos. *17* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Black*5-SINGLE, MARRIED, *Married*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Unknown, 1885
(Month) (Day) (Year)

7-AGE,

*30*If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*(b) General nature of industry, business, or establishment in which employed (or employer). *Unknown*

9-BIRTHPLACE, (State or Country),

Va.

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *McGee, J. D.*(Address) *1111 1st St.*

15-

Filed

SEP 10 1915

191

HARRY O. ANDERSON

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

September 8, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Aug 22 1915, to Sept 8 1915*that I saw him alive on *Sept 8 1915*and that death occurred, on the date stated above, at *11* m.

The CAUSE OF DEATH* was as follows:

*Chronic Myocarditis**Not known* (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Pericarditis (Duration) *Not known* yrs. ... mos. ... ds.(Signed) *J. D. McGee* M. D.*9/8, 1915* (Address) *1111 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. *17* ds. In the State ... yrs. ... mos. *17* ds.Where was disease contracted, if not at place of death? *Charlottesville Va*Former or usual residence *Onancock Va*

19-PLACE OF BURIAL OR REMOVAL,

Onancock Va

DATE OF BURIAL,

Sept 10, 1915

20-UNDERTAKER

Joe B Coates

ADDRESS

1843 West 8 Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88083

C88083

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *8 on Shuter*)

ST.:

WARD:

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *8 on Shuter*)

St.:

Yrs.:

mos.:

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*colored*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
widow

6-DATE OF BIRTH.

Unknown, 1
(Month) (Day) (Year)

7-AGE.

61 yrs. mos. ds.

If LESS than 1 day.

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Cook*
*Private*9-BIRTHPLACE,
(State or Country).*Baltimore Md*

10-NAME OF FATHER

*Thos Reid*11-BIRTHPLACE OF FATHER
(State or Country),*Md*

12-MAIDEN NAME OF MOTHER

*Henretta Wilks*13-BIRTHPLACE OF MOTHER
(State or Country),*Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Susan Chase*(Address) *8 on Shuter St*

15-

SEP 10 1915 HARRY O. ANDREWS,
Filed SEP 10 1915 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 9th 191*5*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 5 191*5*, to *Sept 9* 191*5*that I saw him alive on *Sept 8* 191*5*and that death occurred, on the date stated above, at *7:45* m.

The CAUSE OF DEATH* was as follows:

*mitral Insufficiency**unknown* (Duration) yrs. mos. ds.CONTRIBUTORY *Cardiac Dropsy*
(Secondary)*three months* (Duration) yrs. mos. ds.(Signed) *Edward F. Fisher M. D.**Sept 10* 191*5*. (Address) *1652 E. Monument St*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Leavel Hunt *Sept 13* 191*5*

20-UNDERTAKER

ADDRESS

Theodore White *1702 South*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. **2835 Riggs Ave.**ST.: **16** WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME **Rose Riley.**(Residence in Baltimore: No. **2835 Riggs Ave.**St.: **Lifetins.** yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, **Married**
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 26th. 1883, 1
(Month) (Day) (Year)

7-AGE,

32 yrs. **1** mos. **13** ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),**Baltimore**

PARENTS.

10-NAME OF FATHER,

Nicholas Washburn,11-BIRTHPLACE OF FATHER
(State or Country),**Baltimore**

12-MAIDEN NAME OF MOTHER

Alice Willians13-BIRTHPLACE OF MOTHER
(State or Country),**Boston Mass.**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Daniel L. Riley.**(Address) **2835 Riggs Ave.**

15-

Filed

SEP 10 1915

DANNY O. ANDERSON,

191...
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 8, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from **May 2** 1915, to **Sept 8** 1915, that I saw her alive on **Sept 8** 1915, and that death occurred, on the date stated above, at **11 30** m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Tuberculosis
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY
(Secondary)(Duration) ... yrs. ... mos. ... ds.
(Signed) **Dr. Delany Thomas M. D.**
Sept 10, 1915 (Address) **3304 Charles St.**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmount Cem. **9/11, 1915**

20-UNDERTAKER

ADDRESS

East. Wm. & Son 118 Wm. Royal Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1108 N. Mount* ST.; *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1108 N. Mount* St.; *45* yrs., mos. da)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Unknown, 1835
(Month) (Day) (Year)

7-AGE,

80 yrs. mos. da.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*9-BIRTHPLACE,
(State or Country).*Pennsylvania*

10-NAME OF FATHER,

*Francis Gates*11-BIRTHPLACE OF FATHER
(State or Country).*Germany*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country).*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Jones*(Address) *1108 N. Mount St.*

15-

SEP 10 1915
Filed *191* HARRY O. ANDREWS, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 8, 191*5*
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Mich. 18* 191*5*, to *Sept 8* 191*5*, that I saw her alive on *Sept 8* 191*5*, and that death occurred, on the date stated above, at *4* ^{*PM*} m.

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach
(Clinical Diagnosis)
(Duration) *1* yrs. mos. da.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. mos. da.
(Signed) *O. N. Duwall* M. D.
9/8, 191*5* (Address) *1817 N. Fulton Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *45* yrs. mos. da. In the *45* yrs. mos. da. State

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

Sept. 11, 1915

20-UNDERTAKER

John J. Cowan

ADDRESS

901 Hollister

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from
Sept. 3, 1915, to Sept. 6, 1915,
that I saw her alive on Sept. 6, 1915,
and that death occurred, on the date stated above, at 4:15 p.m.
The CAUSE OF DEATH* was as follows:

Dyscolitis

(Duration) yrs. 3 mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Sept. 5, 1915

(Address)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. 3 mos. ds. State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

18-

SEP 10 1915

HARRY O. ANDERSON, REGISTRAR

HOPKINS HOSPITAL

Sept 9, 1915

Commissioner of Health

FOR ANATOMICAL PURPOSES

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hospital* ST. *14* WARD)REGISTERED NO. C *88082*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Louis E. Lettier*(Residence in Baltimore: No. *1908 Pennsylvania Ave* St. *50* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *female*4-COLOR OR RACE, *white*5-SINGLE, MARRIED, *married*, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *Unknown*, 1861

(Month)

(Day)

(Year)

7-AGE, *54*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *James Beomnell*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER, *Emily*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louis Lettier*(Address) *1908 Penna. Ave*

15-

SEP 10 1915

HARRY O. ANDREWS,

REG.

1915

Baltimore

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 8*, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 1* 1915, to *Sept 8* 1915, that I saw her alive on *Sept 8* 1915, and that death occurred, on the date stated above, at *1:05 A* m.

The CAUSE OF DEATH* was as follows:

*Myocarditis - Chronic
Interrittant nephritis -
Chronic of Stomach
not 3 years (Duration) not known.*CONTRIBUTORY *acute cardiac dilatation* (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Osmond V. Pinchard* M. D.*Sept 8*, 1915. (Address) *St. Joseph Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *3* mos. *1* ds. In the *54* yrs. mos. ds.Where was disease contracted, if not at place of death? *not known*Former or usual residence *1908 Penna. Ave.*19-PLACE OF BURIAL OR REMOVAL, *London Park*DATE OF BURIAL, *Sept 12, 1915*20-UNDERTAKER, *McLean & Jones*ADDRESS, *833 Linden Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88088

C88088

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *4* WARD)2-FULL NAME *Emma Hynes*(Residence in Baltimore: No. *University Hospital* St.: *4* yrs. *1* mos. *15* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH.

Unknown 1
(Month) (Day) (Year)

7-AGE.

38

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE, (State or Country).

Maryland

10-NAME OF FATHER.

Peter Metzger

11-BIRTHPLACE OF FATHER (State or Country).

Md

12-MAIDEN NAME OF MOTHER.

Lydia Ridgley

13-BIRTHPLACE OF MOTHER (State or Country).

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. J. G. J.*(Address) *Univ. Hospital*

15-

Filed

191

HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

September 9, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 8, 1915*, to *Sept 9, 1915*, that I saw her alive on *Sept 8, 1915*, and that death occurred, on the date stated above, at *10 9* m.

The CAUSE OF DEATH* was as follows:

Lymphoid Gland(Duration) yrs. *1* mos. *15* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *M. J. G. J.* M. D.191... (Address) *Univ. Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *15* ds. In the *38* yrs. mos. ds.Where was disease contracted, if not at place of death? *Mt. Vernon Md*Former or usual residence *Mt. Vernon Md*

19-PLACE OF BURIAL OR REMOVAL.

New Cathedral

DATE OF BURIAL.

Sept. 11, 1915

20-UNDERTAKER

A. S. Smith

ADDRESS

1921 W. Pratt St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88089

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *715- Gold*)

ST. *15* WARD)

FULL NAME *Mrs. Alexia Savary*

(Residence in Baltimore: No. *715- Gold*)

Str.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow*

6 DATE OF BIRTH *Unknown, 1830*

7 AGE *80* yrs. - mos. - ds. If LESS than 1 day, - hrs. or - min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *House work* (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Maryland*

10 NAME OF FATHER *Andrew Scott*

11 BIRTHPLACE OF FATHER (State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Mary Garrett*

13 BIRTHPLACE OF MOTHER (State or country) *Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Savage Williams* (Address) *715 Gold St*

15 SEP 10 1915

HARRY C. ALLEN
Muriel Peritt Allen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 8, 1915*

17 I HEREBY CERTIFY, That I attended deceased from *July 1, 1915* to *Sept 8, 1915* that I saw him alive on *Sept 8, 1915* and that death occurred, on the date stated above, at *8 AM*. The CAUSE OF DEATH* was as follows:

*Chronic interstitial
nephritis*

(Duration) yrs. *2* mos. *3* ds.

Contributory (SECONDARY) *Stomach*

(Duration) yrs. mos. ds.

(Signed) *R. R. H. H.* M. D. *9/8, 1915* (Address) *713 Gold St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Auburn

Sept 10, 1915

20 UNDERTAKER

ADDRESS

John H. Toadman

142 Hill St

STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C88090

CERTIFICATE OF DEATH

C88090

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *1124 Hanover*)

ST. *23* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Charles Edward Shea*

(Residence in Baltimore: No. *1124 Hanover*)

St. *—* yrs. *6* mos. *19* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the words)

6-DATE OF BIRTH *February 20, 1915*
(Month) *1* (Day) (Year)

7-AGE *—* yrs. *6* mos. *19* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *None* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore Md*

10-NAME OF FATHER *John J Shea*

11-BIRTHPLACE OF FATHER (State or country) *Baltimore Md*

12-MAIDEN NAME OF MOTHER *Louisa C Beck*

13-BIRTHPLACE OF MOTHER (State or country) *Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE *Mrs Louisa C Shea (mother)*
(Informant)

(Address) *1124 Hanover St*

15-SEP 10 1915 HARRY O. ANDREAS, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *September 8, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY That I attended deceased from *June 1, 1915* to *Sept 8, 1915*, that I saw him alive on *September 8, 1915* and that death occurred, on the date stated above, at *7:00* m. The CAUSE OF DEATH* was as follows:

Myocarditis
asphyxiated

Contributory (SECONDARY) *Exhaustion*
(Duration) yrs. *3* mos. *—* ds.

(Signed) *Otto M Reinhardt* M. D.
Sept 9, 1915 (Address) *1017 S Charles St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL *Cathedral Cemetery Sept 10, 1915*

20-UNDERTAKER ADDRESS *J. & M. S. Flynn 1422 Light St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88091

CERTIFICATE OF DEATH.

151

C88091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1432 Battery ave

ST.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Joseph Reiley

(Residence in Baltimore: No.

1432 Battery ave

St.; yrs. mos. 5 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

Single

6-DATE OF BIRTH,

Sept 4, 1915

(Month)

(Day)

(Year)

7-AGE,

4 yrs. 4 mos. 4 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE, (State or Country),

Balto, Md

10-NAME OF FATHER,

Joseph J. Reiley

11-BIRTHPLACE OF FATHER (State or Country),

Balto, Md

12-MAIDEN NAME OF MOTHER

Annie Wendel

13-BIRTHPLACE OF MOTHER (State or Country),

Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Reiley

(Address)

1432 Battery ave

15-

Filed

SEP 10 1915

HARRY O. ANDREWS

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 5, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 4 1915, to Sept 8 1915

that I saw him alive on Sept 8 1915

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Premature baby weighing 3 pounds

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Convulsions

(Duration) yrs. mos. ds.

(Signed) Jas. A. O'Connell M. D.

Sept 8 1915 (Address) 107 E. McLean

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Cross Cemetery

Sept 12, 1915

20-UNDERTAKER

H. M. Flynn

ADDRESS

1422 Light St

Tony Komonik
HEALTH DEPARTMENT—CITY OF BALTIMORE

+ 104
C88093
CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Mercy Hospital* 4
CITY OF BALTIMORE: (No. *15* ST. WARD) REGISTERED No. C
2-FULL NAME *Tony Komonik* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *15* *Mercy Hospital* and mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single* (Write the word.)
6-DATE OF BIRTH *Jan. 23, 1915*
(Month) (Day) (Year)
7-AGE, *0* yrs. *7* mos. *18* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Ind*

10-NAME OF FATHER *Tony Komonik*
11-BIRTHPLACE OF FATHER (State or Country), *Austria*
12-MAIDEN NAME OF MOTHER *Louise Bohak*
13-BIRTHPLACE OF MOTHER (State or Country), *Austria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Record Mercy Hosp.*
(Address) *Calvert St.*

15- *SEP 10 1915* HARRY O. ANDREWS,
Filed *101* Serial *Permit 0191*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *Sept. 10, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Sept. 7, 1915*, to *Sept. 10, 1915*, that I saw him alive on *Sept. 10, 1915*, and that death occurred, on the date stated above, at *5:45* p.m.

The CAUSE OF DEATH* was as follows:

Alimentary Intoxication
about (Duration) *1* yrs. *1* mos. *18* ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs. *1* mos. *18* ds.
(Signature) *Edward Smith* M. D.
Sept. 10, 1915 (Address) *Mercy Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *3* yrs. *3* mos. *18* ds. In the State *Ind*

Where was disease contracted, if not at place of death? *From Food*

Former or usual residence *Spacious Point Ind.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

St Stanislaus *Sept. 11, 1915*

20-UNDERTAKER ADDRESS

Max Croch Son *1804-66 Oakland*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 811 N. Monroe street, ST. 16 WARD)

2-FULL NAME

Irene D. Nye,

(Residence in Baltimore: No. 811 N. Monroe street,

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female,

4-COLOR OR RACE,

White,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married,

6-DATE OF BIRTH,

March 17th, 1880.

7-AGE,

35 yrs., 5 mos., 23 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

James J. Catterton,

11-BIRTHPLACE OF FATHER

(State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Jane M. Dalby,

13-BIRTHPLACE OF MOTHER

(State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Van Horn Nye, husband

(Address) 811 N. Monroe street.

15-

SEP 11 1915

ROBERT KRAUTER
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 9th, 1915.

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry find that said deceased came to death (Inquest, au-
topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute alcoholism.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dipsomania.

(Duration) 4 yrs. mos. ds.

(Signed) J. Frederick Neupel, M. D.

(Coroner.)

Sept. 9, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 963 N. Collington ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilhelmina Volkman(Residence in Baltimore: No. 963 N. Collington Ave St.; 20 yrs., 10 mos., 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female4-COLOR OR RACE, White5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, Jan, 1863

(Month)

(Day)

(Year)

7-AGE, 528 yrs., 8 mos., 10 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, Karl Volkman11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER, Not Known13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emil Volkman(Address) 963 N. Collington

15-

SEP 11 1915

ROBERT KRAUTER

Filed..... 191... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September, 9th, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from February 1914, to September 1915, that I saw her alive on September 7th 1915, and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Clinical Diagnosis
Leucemia of Lutea
+ Kidney(Duration) 1 yrs. 8 mos. 10 ds.

CONTRIBUTORY..... (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Albert G. Kingma9/10/1915 (Address) 1503 S. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western CemeteryDATE OF BURIAL, Sept. 11, 191520-UNDERTAKER, Harris & CoADDRESS, 2008 Alameda

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.; *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Johns Hopkins Hosp* St.; *7* yrs., *7* mos., *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

*March**20**1876*

(Month)

(Day)

(Year)

7-AGE,

*39**5**mos.**21**ds.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Electrician

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

England

10-NAME OF FATHER,

John Haigh

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

Ann Gattier

13-BIRTHPLACE OF MOTHER (State or Country),

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. J. Smith*(Address) *Johns Hopkins Hosp*

15-

SEP 11 1915

Filed

191

ROBERT KRAUTER

Bureau Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*September**10**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*September 3, 1915, to September 10, 1915,*that I saw him alive on *September 10, 1915,*and that death occurred, on the date stated above, at *7³⁰ a.m.*

The CAUSE OF DEATH* was as follows:

*Brain Tumor**Dural Endothelioma fully certain*

(Duration)

*3**mos.**1**ds.*

CONTRIBUTORY (Secondary)

(Duration)

*3**yrs.**1**mos.**1**ds.*

(Signed)

W. E. Donohue M. D.*Sept 10, 1915.* (Address) *Johns Hopkins Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

*7**ds.*

In the

*State**7**yrs.**7**mos.**7**ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

Hagerman N. Y.

19-PLACE OF BURIAL OR REMOVAL,

Lowell Mass

DATE OF BURIAL,

Sept 10, 1915

ADDRESS

121 N Broadway

20-UNDERTAKER

Arthur C. Fuller

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.: 70 yrs. 5 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH April 1836 (Month) (Day) (Year)

7-AGE 79 yrs. 5 mos. 30 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

PARENTS

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept 10, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from January 1902 to Sept 1915, that I saw her alive on Sept 1915, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Arthritis deformans

20-Contributory (SECONDARY) Kidney disease (Duration) 10 yrs. mos. ds. (Signed) B. B. Brown M. D. Sept 10, 1915 (Address) 510 Park St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

15.

SEP 11 1915

ROBERT KRAUTER,

Baltimore Health Clerk,

REGISTRAR

London Park George J. Smith

N. Fayette St

is very important. See instructions on back of certificate.

C88099

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88099

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *212 T. armit st* St. *5* WARD)2-FULL NAME *Lellis E. Okluy*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No. *212 T. armit* St. *25* yrs. *25* mos. *25* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE *Married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH *Unknown* 1 (Month) (Day) (Year)7-AGE *70* yrs. *25* mos. *25* ds. or min.?8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Housewife*9-BIRTHPLACE
(State or country)*Baltimore Md*

PARENTS

10-NAME OF FATHER

*Unknown*11-BIRTHPLACE OF FATHER
(State or country)*Unknown*

12-MAIDEN NAME OF MOTHER

*Harriet A. Heller*13-BIRTHPLACE OF MOTHER
(State or country)*Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harriet Crowne

(Address)

Baltimore Md

15-

SEP 11 1915

HARRY O. ANDERSON,

Serial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 8, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 27, 1915*, to *Sept 8, 1915*, that I saw him alive on *Sept 8, 1915*, and that death occurred, on the date stated above, at *3:25 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage(Duration) yrs. *1* mos. *13* ds.Contributory
(SECONDARY)(Duration) yrs. *1* mos. *13* ds.(Signed) *Robert J. Green* M.D.
Sept 10, 1915 [Address] *120 1/2 Disquisition St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. *1* mos. *13* ds. In the State yrs. *1* mos. *13* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. John's Roman Catholic Church**SEP 11 1915*

20-UNDERTAKER

ADDRESS

*Samuel J. Kennedy**578 N. Biddle*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88100

28 C88100

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2650 Boone* ST. *9* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2650 Boone St* St. *Lifetime* da)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*Colored*5-SINGLE, MARRIED, *Married*, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

Unknown, 1889
(Month) (Day) (Year)

7-AGE,

26 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Domestic*
(b) General nature of industry, business, or establishment in which employed (or employer). *General house work*

9-BIRTHPLACE, (State or Country),

Baltic City Maryland

10-NAME OF FATHER,

James Duckett

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Susan Smoot

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Dunsall*(Address) *2650 Boone St*

15-

SEP 11 1915

HARRY O. ANDREWS

Filed

191

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 9, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Aug 8 1915* to *Sept 9 1915*; that I saw her alive on *Sept 9 1915*; and that death occurred, on the date stated above, at *11:30* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Indefinite
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *P. Garbutt* M. D.
Sept 10, 1915 (Address) *424 East 23 St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Paul Cemetery**Sept 12 1915*

20-UNDERTAKER

ADDRESS

Robt. A. Elliott. 506 Rogers Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 Myrtle Ave ST.; 17 WARD)

2-FULL NAME

Conrad Rheinhardt

(Residence in Baltimore: No.

1217 Myrtle Ave

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 61 yrs., 6 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH

Sept. 25, 1848
(Month) (Day) (Year)

7-AGE

66 yrs., 11 mos., 15 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed. (or employer).Clerk
unknown

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Conrad Rheinhardt

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Annie M. Gerlach

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Louisa Rheinhardt

(Address)

1217 Myrtle Ave.

15-

SEP 11 1915

HARRY O. ANDREWS,

Filed

101

Bureau of Health, D. O. H. & H.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 8, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 1st 1915, to Sept 8th 1915, that I saw him alive on Sept 8th 1915, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy(Duration) one hour yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

Wm. Pearce M. D.

(Address)

5-E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 0 mos. 0 ds. In the State yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Baltimore CemeterySept 12, 1915

20-UNDERTAKER

ADDRESS

Philip Seewald109 S. Cutaw St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88102

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *9 W-29th*)ST.: *12* WARD)REGISTERED NO. C *3*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mannah Hoolen Neily(Residence in Baltimore: No. *9 W-29th*)St.: *71* yrs., *7* mos. *25* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-STATUS, *married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

January 15, 1844
(Month) (Day) (Year)

7-AGE,

*71 yrs., 7 mos., 25 ds.*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, business,
or establishment in which
employed (or employer).....*at home**Housewife*9-BIRTHPLACE,
(State or Country),*Baltimore Md.*10-NAME OF
FATHER,*Washington Hands*11-BIRTHPLACE
OF FATHER
(State or Country),*Baltimore Md.*12-MAIDEN NAME
OF MOTHER*Jane Hoolen*13-BIRTHPLACE
OF MOTHER
(State or Country),*Baltimore Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Joseph W. Neily

(Address).....

9 W-29th St.

15-

SEP 11 1915

HARRY O. ANDREWS,

Filed

Certified to the Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 9th, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from
Sept 11 1915 to *Sept 9th 1915*,
that I saw him alive on *Sept 9th 1915*,
and that death occurred, on the date stated above, at *4:00 P. m.*

The CAUSE OF DEATH* was as follows:

Coronary artery disease
(Pathological changes in coronary arteries)
including atherosclerosis
(Duration)..... yrs. *7* mos. *25* ds.CONTRIBUTORY
(Secondary)(Duration)..... yrs. *7* mos. *25* ds.(Signed)..... *Ernest C. Kellum* M. D.*Sept 11 1915* (Address)..... *1414 E. Eady St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Crownpoint Cemetery

DATE OF BURIAL,

Sept 12, 1915

20-UNDERTAKER

H. E. Hughes

ADDRESS

175 Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *804 S. Robinson*ST.; *1* WARD)

REGISTERED NO. C

FULL NAME

Isa Virginia Neal

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *804 S. Robinson*St.; *47* yrs., *11* mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White**Widow*
SINGLE, WIDOWED, OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

*October**9**1867*

(Month)

(Day)

(Year)

7-AGE.

47 yrs., *11* mos., *2* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

at home

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country).

Baltimore Md

PARENTS.

10-NAME OF FATHER.

Henry Benson

11-BIRTHPLACE OF FATHER

(State or Country).

Baltimore Md

12-MAIDEN NAME OF MOTHER

Harriet Ruley

13-BIRTHPLACE OF MOTHER

(State or Country).

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Immie Groucher (daughter)*(Address) *804 S. Robinson St.*

15-

SEP 11 1915

Filed..... 191.....

HARRY O. ANDREWS,

Baltimore City Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*September**11th**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *August 3rd 1915* to *Sept 11th 1915*, that I saw her alive on *Sept 10th 1915*, and that death occurred, on the date stated above, at *2:00 A.M.*

The CAUSE OF DEATH* was as follows:

uracemia & heart exhaustion... following an influenza attack... removed an inflamed appendix & an ovarian cyst 7 weeks ago.

CONTRIBUTORY (Secondary)

heart exhaustion...(Duration) *3* mos. *3* ds.(Signed) *R. T. Harris* M. D.Sep. 11, 1915. (Address) *1902 Brook St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Baltimore Cemetery

DATE OF BURIAL.

Sept 11, 1915

20-UNDERTAKER

J. E. Hughes

ADDRESS

17 S. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 N. Bethel ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore, No. 1608 N. Bethel St. St. Life yrs., mos. ds.)
Married to Rev. St. Thomas Division as Marie Menke

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

May 30, 1899
(Month) (Day) (Year)

7-AGE,

16 yrs. 3 mos. 11 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Sales Girl
Louis Dept. Store9-BIRTHPLACE,
(State or Country).Balto. Md.

PARENTS.

10-NAME OF FATHER,

William Menke

11-BIRTHPLACE OF FATHER

(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Charlotte Schmus

13-BIRTHPLACE OF MOTHER

(State or Country).

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William Menke

(Address)

1608 N. Bethel

15-

FILED

SEP 11 1915

HARRY C. ANDREWS,

BRIAN ROYALL CLARK,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 10, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

July 24 1915, to Sept 10 1915,that I saw him alive on Sept 10 1915,and that death occurred, on the date stated above, at 2.20 pm.

The CAUSE OF DEATH* was as follows:

GastritisCONTRIBUTORY
(Secondary)

(Duration)....yrs....1...mos...16...ds.

(Signed) Geo. J. Young M. D.Sept 10, 1915. (Address) 1531 E. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cem.

DATE OF BURIAL,

Sept. 13, 1915

20-UNDERTAKER

Mr. & Mrs. Geo. W. Zupfel

ADDRESS

801 W. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *7* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *837 Hollins* St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Baby*

6-DATE OF BIRTH,

September 8, 1915
(Month) (Day) (Year)

7-AGE,

0 yrs. 0 mos. 0 ds.

If LESS than 1 day,

7 hrs. or 35 min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*infant*

9-BIRTHPLACE,

(State or Country), *Johns Hopkins Hosp. Maryland*

10-NAME OF FATHER,

Jacob Lipschutz

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Eva Boyser

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Wm. J. McCall*(Address) *Johns Hopkins Hosp.*

15-

*SEP 11 1915**HARRY O. JOHNS*Filed....., 1915 *Marial. Permt. Clara*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 8, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept. 8 A.M. 1915*, to *Sept. 8 P.M. 1915*, that I saw her alive on *Sept. 8 A.M. 1915*, and that death occurred, on the date stated above, at *7 A.M.*

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage following rupture of basilar artery in breech extraction.(Duration) *0 yrs. 6 mos. 9 ds.*

CONTRIBUTORY (Secondary)

Breech extraction (Duration) *0 yrs. 6 mos. 9 ds.*(Signed) *Wm. J. McCall**Sept. 9, 1915* (Address) *Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0 yrs. 0 mos. 1/2 ds.* In the State *0 yrs. 0 mos. 1/2 ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

HOPKINS HOSPITAL

DATE OF BURIAL,

SEP. 9, 1915

20-UNDERTAKER

Commissioner Health

ADDRESS

FOR ANATOMICAL PURPOSES.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1544 N Fremont Ave ST. 15 WARD)

2-FULL NAME

John Wesley Goldborough Jr

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11L.)

(Residence in Baltimore: No. 1544 N Fremont Ave St.; yrs. mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

Aug
(Month)

23, 1915
(Day) (Year)

7-AGE

yrs. 17 mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Balto Md.

10-NAME OF FATHER

John Wesley Goldborough

11-BIRTHPLACE OF FATHER
(State or country)

Talbot Co. Md.

12-MAIDEN NAME OF MOTHER

Rebecca Toliver

13-BIRTHPLACE OF MOTHER
(State or country)

Lancaster Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. William Fey

(Address)

1928 Penna Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 10, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 8, 1915, to, Sept 10, 1915,

that I saw him alive on Sept 10, 1915,

and that death occurred, on the date stated above, at 9.50 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 2 ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) W. William Fey M.D.

Sept 10, 1915 [Address] 928 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?
If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

W. Zion

Sept 11, 1915

20-UNDERTAKER

ADDRESS

James H. Dineen 13030 Roston

SEP 11 1915
Filed....., 191

HARRY O. ANDREAS
Marial Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 N. Monroe ST.; 20 WARD)2-FULL NAME Eaton A. Sims(Residence in Baltimore: No. 201 N. Monroe St.; 12 yrs., 12 mos., 12 da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH.

Feby 5, 1881
(Month) (Day) (Year)

7-AGE.

34 yrs., 7 mos., 5 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Dentist
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Louise Co. Va

PARENTS.

10-NAME OF FATHER.

Oliver C Sims

11-BIRTHPLACE OF FATHER

(State or Country), Va

12-MAIDEN NAME OF MOTHER

Lydia A. Walton

13-BIRTHPLACE OF MOTHER

(State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leone Sims(Address) 201 N Monroe

15-

Filed

SEP 11 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 10, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 6 1915, to Sept 10 1915, that I saw him alive on Sept 10 1915, and that death occurred, on the date stated above, at 10:10 PM.
The CAUSE OF DEATH* was as follows:

The CAUSE OF DEATH* was as follows:

Acute Septic
Endocarditis
(Duration)yrs. 1 1/2 mos.ds.

CONTRIBUTORY (Secondary)

Coronary Arteriosclerosis
(Duration)yrs.mos.ds.(Signed) J. B. Deanehouse M. D.9.10.15 (Address) 1532 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death? At homeFormer or usual residence 201 N Monroe St C.

19-PLACE OF BURIAL OR REMOVAL.

Maiden Va DATE OF BURIAL SEP 12, 1915

20-UNDERTAKER

W. Cook ADDRESS 502 E North
ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88108

CERTIFICATE OF DEATH.

45

C88108

1-PLACE OF DEATH

1026 Hanford Ave.

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1026 Hanford Ave. ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Lillian L. Weisheit

(Residence in Baltimore: No.

1026 Hanford Ave.

St.; — yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Unknown, 1863

(Month)

(Day)

(Year)

7-AGE,

52

yrs.

mos.

da.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).

Gen. House

9-BIRTHPLACE, (State or Country),

New Jersey

10-NAME OF FATHER,

Carl Nagel

11-BIRTHPLACE OF FATHER (State or Country),

N.J.

12-MAIDEN NAME OF MOTHER

Dora Knorr

13-BIRTHPLACE OF MOTHER (State or Country),

Dout Knorr

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. E. G. McDaniel

(Address)

1036 Hanford Ave.

15-

SEP 11 1915

Filed

102

HARRY O. ANDERSON, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 10, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1, 1915, to Sept 10, 1915.

that I saw her alive on Sept 1, 1915,

and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of

bladder

Clinical Diagnosis

CONTRIBUTORY (Secondary)

(Signed) E. G. McDaniel M. D.

Sept 10 1915 (Address) E. G. McDaniel, Baltimore, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore County

DATE OF BURIAL,

Sept 11, 1915

20-UNDERTAKER

Wm Cook

ADDRESS

505 E. North

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88109

CERTIFICATE OF DEATH

C88109

1 PLACE OF DEATH

28
REGISTERED NO. C

CITY OF BALTIMORE: (No. 1623 N Calhoun

ST. 15

WARD)

2-FULL NAME

William Arthur Cole

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1623 N Calhoun

St. 26 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Mar

10, 1889

(Month)

(Day)

(Year)

7-AGE

26

yrs.

6

mos.

ds.

or

min.?

If LESS than

1 day,

hrs.,

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Porter

9-BIRTHPLACE

(State or country)

Balto Md.

PARENTS

10-NAME OF FATHER

Stanley Cole

11-BIRTHPLACE OF FATHER
(State or country)

Charles Co. Md.

12-MAIDEN NAME OF MOTHER

Martha Snowden

13-BIRTHPLACE OF MOTHER
(State or country)

A. A. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. William Fier M.D.

(Address)

1928 Penna Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept

10

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 15, 1915, to Sept 10, 1915,

that I saw him alive on Sept 10, 1915,

and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Tubercular Pneumonia

(Duration)

yrs

mos

ds

Contributory
(SECONDARY)

(Duration)

yrs

mos

ds

(Signed)

E. William Fier

M. D.

Sept 10, 1915

[Address]

1928 Penna Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs

mos

In the

ds

State

yrs

mos

ds

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buried in

Sept 15, 1915

UNDERTAKER

ADDRESS

Baltimore 11364 Carey

15-

Filed

191

HARRY C. ANDREWS

Marial Permit Officer

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

SEP 11 1915

C88110

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Linden Ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Betty Sperling

(Residence in Baltimore: No.

2016 Linden Ave

St.: 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-STATUS

WIDOWED

(Write the word.)

6-DATE OF BIRTH

November, 1837

7-AGE

77 yrs. 10 mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Germany -

10-NAME OF FATHER

Simon Wolf

11-BIRTHPLACE OF FATHER
(State or Country),

Germany -

12-MAIDEN NAME OF MOTHER

No not know

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Strauss

(Address) 2016 Linden Ave

15-

When

SEP 11 1915

191

HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept. 10, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1915, to Sept 10 1915, that I saw her alive on Sept 10 1915, and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -
 Mitral Regurgitation -
 Aortic Stenosis -

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Cardiac Dilatation

(Duration) 15 yrs. mos. ds.

(Signed) Dr. Cohen M. D.

Sept 10, 1915. (Address) 1820 Eaton Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Ochet Sholam Cem.

DATE OF BURIAL

9/11/15

20-UNDERTAKER

David Kondheim 118 W. Royal Ave

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88111

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *Johns Hopkins Hospital* St.; yrs. *1* mos. *4* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

Feb. 6, 1873
(Month) (Day) (Year)

7-AGE.

42 yrs. *7* mos. *4* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Farmer.*

9-BIRTHPLACE, (State or Country),

ind.

PARENTS.

10-NAME OF FATHER,

Jas B. Garrett

11-BIRTHPLACE OF FATHER

(State or Country), *va.*

12-MAIDEN NAME OF MOTHER

Henrietta Garrett

13-BIRTHPLACE OF MOTHER (State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Phelps*(Address) *Johns Hopkins Hospital*

15-

SEP 11 1915
Fried. 191.

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

September 18, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 11, 1915* to *Sept 18, 1915*, that I saw him alive on *Sept 18, 1915*, and that death occurred, on the date stated above, at *7:45 p.m.*

The CAUSE OF DEATH* was as follows:

Mitral stenosis and insufficiency
(Duration) *Not known* ds.

CONTRIBUTORY (Secondary)

(Signed) *Paul H. Blount* M. D.
Sept 11, 1915 (Address) *Johns Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *4* ds. In the State *40* yrs. *7* mos. *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Mascott, Va.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Grayson Va *Sept 11, 1915*

20-UNDERTAKER

ADDRESS

Wm E Fuller *221 N Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____)

2-FULL NAME

(Residence in Baltimore: No. _____)

REGISTERED NO. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH

October

5

1876

(Month)

(Day)

(Year)

7-AGE,

38 yrs. 11 mos. 5 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Sneeman (Elect)

9-BIRTHPLACE, (State or Country),

Tenn.

10-NAME OF FATHER,

W. M. Jackson.

11-BIRTHPLACE OF FATHER (State or Country),

Tenn.

12-MAIDEN NAME OF MOTHER

Nellie Galyan.

13-BIRTHPLACE OF MOTHER (State or Country),

Tenn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

O. Phelps
Johns Hopkins Hosp.

15-

Filed.....

191.....

HARRY O. ANDREWS
REGISTRAR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

September

10

1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from Aug. 24 1915 to Sept. 10 1915 that I saw him alive on Sept 10 1915, and that death occurred, on the date stated above, at 6¹⁵ p.m.

The CAUSE OF DEATH* was as follows:

pneumonia

CONTRIBUTORY (Secondary)

Operation (Cancer) (Signed) M. D. Sept. 11, 1915. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. 17 mos. 17 ds. In the State..... yrs. 5 mos. 17 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Williamsburg, Ky.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Williamsburg, Kentucky

Sept. 11, 1915.

20-UNDERTAKER

ADDRESS

Albert E. Fuller

221 N. Broadway

W. G. Bunker M. D.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88113

C88113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.; *6* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1531 Orleans St.* St.; *5* yrs., *2* mos., *27* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) *Single*

6-DATE OF BIRTH,

Mar., *14*, *1915*
(Month) (Day) (Year)

7-AGE,

5 yrs., *2* mos., *27* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE,

(State or Country), *Balto.*

PARENTS.

10-NAME OF FATHER,

Antonio Sadowski

11-BIRTHPLACE OF FATHER (State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Mary A. Zeech

13-BIRTHPLACE OF MOTHER (State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Antonio Sadowski*(Address) *1531 Orleans St.*

15-

Filed *SEP 11 1915*

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DASHY O. ANDERSON,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept., *9*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 8, *1915*, to *Sept. 9*, *1915*that I saw him alive on *Sept. 9*, *1915*and that death occurred, on the date stated above, at *3:55 A.M.*

The CAUSE OF DEATH* was as follows:

*Intestinal Decomposition**about* (Duration) *1* yrs., *1* mos., *1* ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs., *1* mos., *1* ds.(Signed) *Edward Smith* M. D.*Sept. 9*, *1915*. (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs., *1* mos., *1* ds. In the State *Life*Where was disease contracted, if not at place of death? *1531 Orleans St.*Former or usual residence *1531 Orleans St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Mary's Hospital *Sept. 12 1915*

20-UNDERTAKER

ADDRESS

Wendell Giffel & Son *37 S. Ann. St.*

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88114

CERTIFICATE OF DEATH

C88114

PLACE OF DEATH

Melvin Norman

REGISTERED NO. C

CITY OF BALTIMORE (No.

231 Sweet Air St

ST.

13

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Melvin Norman

(Residence in Baltimore: No.

231 Sweet Air St.

Sr.

2 yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

July 30, 1912

7-AGE

3 yrs. 1 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

cr

9-BIRTHPLACE
(State or country)

Va

10-NAME OF FATHER

Frank Norman

11-BIRTHPLACE OF FATHER
(State or country)

Va

12-MAIDEN NAME OF MOTHER

May Leonard

13-BIRTHPLACE OF MOTHER
(State or country)

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Norman

(Address)

231 Sweet Air St

15-

Filed

SEP 11 1915

191

HARRY O. ANDREWS,

Morial Permit REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept. 11, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 9, 1915, to, Sept. 11, 1915,

that I saw him alive on Sept. 10, 1915,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) M. D.

Sept. 11, 1915 (Address) 846 W. 26th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Marys Hospital, Sept. 12, 1915

20-UNDERTAKER

ADDRESS

Chenoweth & Son, Chestnut

8 A. M.

At 8 A. M.

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88115

C88115

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

CITY OF BALTIMORE: (No. *1108 m Crass*)REGISTERED NO. C. *120*2-FULL NAME *Thomas P Hill*ST. *21* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1108 m Crass*)St.: _____ yrs., *4* mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,

married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Feb 7, 1856
(Month) (Day) (Year)

7-AGE,

*58 yrs. 7 mos. 2 ds.*If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Shoemaker*9-BIRTHPLACE,
(State or Country),*Laurel Md*

10-NAME OF FATHER,

*Humphrey C Hill*11-BIRTHPLACE OF FATHER
(State or Country),*Va*

12-MAIDEN NAME OF MOTHER

*Mary Buckels*13-BIRTHPLACE OF MOTHER
(State or Country),*Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Margaret Hill*(Address) *1108 m Crass*

15-

SEP 11 1915

Filed.....

191..

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 9, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Aug 28* 1915, to *Sept 8* 1915, that I saw him alive on *Sept 8* 1915, and that death occurred, on the date stated above, at *10.05* m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis(Duration) *12* yrs. *10* mos. *2* ds.CONTRIBUTORY
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *M. D. R. Cox* M. D.*9-10, 1915* (Address) *341 Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL,

Melville M C Cemetery
Chesapeake-2nd

DATE OF BURIAL,

Sept 12, 1915

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 W 29th
Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88116

C88116

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2015 Maryland Ave.* ST. *12* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *2015 Maryland Ave* St.; yrs., mos., *23* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *Single*
(Write the word.)6-DATE OF BIRTH, *Aug. 19*, 19*15*
(Month) (Day) (Year)7-AGE, *23* yrs., mos., ds. If LESS than 1 day,hrs. or....min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Robert Venables*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER, *Esther Dougherty*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *(Res) H. F. Venables*(Address) *816 No. Eutaw St. City*15-SEP 11 1915
Filed..... 191.....
HARRY O. ANDREWS,
REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 11*, 19*15*
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Aug 19* 191*5*, to *Sept. 11* 191*5*, that I saw h *not* alive on *Sept. 11* 191*5*, and that death occurred, on the date stated above, at *1130 A.M.*

The CAUSE OF DEATH* was as follows:

Premature Death(Duration).....yrs.....mos.....ds.
CONTRIBUTORY.....
(Secondary) *Concurrent Debility*(Signed).....*H. F. Venables*.....M. D.
Sept. 11, 191*5*. (Address).....*127 E. North St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Goudon Park Cem* DATE OF BURIAL, *Sept. 11*, 191*5*20-UNDERTAKEN *Henry W. Jenkins Co* ADDRESS *Orchard*

C88117

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88117

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital* 4 REGISTERED NO. C.....
 CITY OF BALTIMORE: (No. ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME *John F. Beck*
 (Residence in Baltimore: No. *University Hospital* St.: yrs., 1 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
 6-DATE OF BIRTH, *unknown, 1877*
 (Month) (Day) (Year)

7-AGE, *38* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, *jeweler*
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Canada*

10-NAME OF FATHER, *Unknown*
 11-BIRTHPLACE OF FATHER (State or Country), *Unknown*
 12-MAIDEN NAME OF MOTHER *Unknown*
 13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *G. F. Beck*
 (Address) *Maedon Mass*

15- SEP 11 1915 HARRY O. ANDREWS,
 Filed..... 191. Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 11*, 1915.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *8/9* 1915, to *9/11* 1915, that I saw him alive on *9/11* 1915, and that death occurred, on the date stated above, at *1:15 p.m.* The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) *unknown* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Cerebral Embolism*

(Duration) *35* yrs. mos. ds.

(Signed) *Wm. Steiner* M. D.
9/11, 1915. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 2 ds. In the *unknown* State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Annapolis, Md.*

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL, *North Belton* *9/11*, 1915.

20-UNDERTAKER ADDRESS *G. F. Wacker 723 W. 4th*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88118

CERTIFICATE OF DEATH.

C88118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2043 Bank ST. 2 WARD)

REGISTERED No. C

2-FULL NAME Lioba C. Collins

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

(Residence in Baltimore: No. 2043 Bank St. 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow
(Write the word.)

6-DATE OF BIRTH, Unknown, 1873.
(Month) (Day) (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House Work
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, Thomas Neuberger

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Eatharine Leimbuehler

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Neuberger
(Address) Raspberg, Balto. Co.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 9, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 16 1913, to Sept. 9 1915, that I saw her alive on Sept. 8 1915, and that death occurred, on the date stated above, at 5:40 p.m. The CAUSE OF DEATH* was as follows:

Uterine Carcinoma
Chronic
(Duration) 2 yrs. mos. ds.
CONTRIBUTORY Uterine Carcinoma
(Secondary) (Duration) 2 yrs. mos. ds.
(Signed) Geo. Heller M. D.
Sept. 11, 1915. (Address) 1937 York St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy RedeemerSept. 13, 1915.

20-UNDERTAKER

ADDRESS

Lilly, Zeiler403 S. Maple

SEP 11 1915

HARRY C. ANDREWS,

Registrar.

C88119

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88119

CERTIFICATE OF DEATH.

151
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Mc Bullish St. ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and about No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1125 Mc Bullish St. St.;

yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Sept 11, 1915

(Month) (Day) (Year)

7-AGE,

yrs. mos. da.

If LESS than 1 day,

Hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Balt. Md.

10-NAME OF FATHER,

Lloyd Luttrell

11-BIRTHPLACE OF FATHER

(State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Myrtle Lee

13-BIRTHPLACE OF MOTHER

(State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lloyd Luttrell

(Address)

1125 Mc Bullish St.

15-

SEP 11 1915

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 11, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 10, 1915, to Sept 11, 1915,

that I saw him alive on Sept 10, 1915,

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Premature delivery birth at mch 7 the month

(Duration)

12 hrs. mos. da.

CONTRIBUTORY
(Secondary)

Transition

(Duration)

yrs. mos. da.

(Signed)

J. H. Plummer, M. D.
Sept 11, 1915 (Address) 921 W. North Ave.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Olive Cemetery

Sept 11, 1915

20-UNDERTAKER

ADDRESS

Wm. Mouton

230 N. E. Ave.

C88120

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88120

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *203 N. Eden* ST. *5* WARD)2-FULL NAME *Henry F. Hooper*(Residence in Baltimore: No. *203 N. Eden* St.; *5* yrs. *1* mos. *1* ds.)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

Unknown, 1875

(Month)

(Day)

(Year)

7-AGE

40

yrs.

mos.

ds.

If LESS than

1 day,

hrs.

or min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

*laborer**Sp. Paint works*

9-BIRTHPLACE

(State or country)

Virginia

10-NAME OF FATHER

Unknown

PARENTS

11-BIRTHPLACE OF FATHER (State or country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mary Johnson*(Address) *203 N. Eden St*

SEP 12 1915

HARRY O. ANDREWS,

Filed

191

Marital Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September 10, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Sept 6, 1915, to, Sept 10, 1915,*that I saw him alive on *Sept 9, 1915,*and that death occurred, on the date stated above, at *6:15* m.

The CAUSE OF DEATH* was as follows:

Fobar Pneumonia

(Duration)

yrs.

mos.

ds.

Contributory (SECONDARY)

Pulmonary Aneurysm

(Duration)

yrs.

mos.

ds.

(Signed)

J. Guy Brown

M. D.

1915

[Address]

136 W. Hill St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

McKuburn Cemetery

DATE OF BURIAL

Sept 12, 1915

20-UNDERTAKER

Charles B. Jones

ADDRESS

11182 Barclay St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88121

C88121

CERTIFICATE OF DEATH.

28
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 239 W. Biddle ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 239 W. Biddle St.; — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Caucasian5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Married

6-DATE OF BIRTH

Unknown, 1.....
(Month) (Day) (Year)

7-AGE

19 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
Domestic9-BIRTHPLACE, (State or Country),
Md

PARENTS.

10-NAME OF FATHER

Joseph Boardley11-BIRTHPLACE OF FATHER (State or Country),
Md

12-MAIDEN NAME OF MOTHER

Eva John13-BIRTHPLACE OF MOTHER (State or Country),
Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hubert E. Step(Address) 239 W. Biddle St

15-

SEP 12 1915. HARRY O. ANDREWS, Registrar.
Filed..... 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

September 10, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 1915, to Sept. 10 1915, that I saw her alive on Sept. 10 1915, and that death occurred, on the date stated above, at 10 P. M. The CAUSE OF DEATH* was as follows:
Pneumonia pulmonis
(Duration)..... yrs. 3 mos. ds.
CONTRIBUTORY... Bronchitis.....
(Secondary) (Duration)..... yrs. mos. 14 ds.
(Signed) Dr. W. S. Carr M. D.
Sept 10 1915 (Address) 515 Mather St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mr. Hubert E. Step Sept. 13 1915

20-UNDERTAKER

ADDRESS

Charles B. Jones 1118 M. Barclay

C88122

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88122

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *1523 McEldery St.* ST. *7* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Bessie Masickoff*(Residence in Baltimore: No. *1523 McEldery St.* ST. *18* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR-DIVORCED

(Write the word)

Widow

6-DATE OF BIRTH

Unknown, 1852

7-AGE

63

yrs.

mos.

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

Russia

10-NAME OF FATHER

Julius Hainstein

11-BIRTHPLACE OF FATHER

(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Ester

13-BIRTHPLACE OF MOTHER

(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Lewis

(Address)

1523 McEldery St.

15-

Filed

SEP 12 1915

HARRY O. ANDREWS,

Baptist Permit Clerk

REGISTRAR

16-DATE OF DEATH

Sept 11, 1915

17- I HEREBY CERTIFY, That I attended deceased from

*Feb 10, 1915, to, Sept 11, 1915.*that I saw him alive on *Sept 11, 1915.*and that death occurred, on the date stated above, at *1:00 p.m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs & kidneys

Contributory

(SECONDARY)

(Duration) *1* yrs. *6* mos. *—* ds.*Edema, ascites, collapse*(Duration) *—* yrs. *—* mos. *8* ds.(Signed) *Joseph Gichner* M. D.*Sept 11, 1915* (Address) *1523 McEldery St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted,

If not at place of death?

Former or usual residence *1523 McEldery St.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Mt. Cemetery *Sept 12, 1915*

20-UNDERTAKER

ADDRESS

Jack Lewis *Balto St*

C88123

HEALTH DEPARTMENT-CITY OF BALTIMORE

C88123

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 2506 Francis St. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Hainer(Residence in Baltimore: No. 2506 Francis St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)6-DATE OF BIRTH Sept 11, 1915
(Month) (Day) (Year)7-AGE 0 yrs. 0 mos. 0 ds. If LESS than 1 day/3 hrs. or 30 min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Infant9-BIRTHPLACE
(State or country)BaltimorePARENTS
10-NAME OF FATHER Edward H. Hainer
11-BIRTHPLACE OF FATHER (State or country) Frederick Co Md
12-MAIDEN NAME OF MOTHER Mamie J. Waller
13-BIRTHPLACE OF MOTHER (State or country) Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward H. Hainer
2506 Francis St
(Address)

15

SEP 12 1915

HARRY O. ANDREWS,

Filed

191

Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept 11, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 11, 1915, to Sept 11, 1915that I saw him alive on Sept 11, 1915and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Infant
This was an eight month child
(Duration) yrs. mos. ds.Contributory
(SECONDARY)(Signed) Frederick B. Bennett M. D.
Sept 11, 1915 (Address) 2635 Penn. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Union Bridge Cem

DATE OF BURIAL

Sept 12, 1915

20-UNDERTAKER

Wm Cook

ADDRESS

104 E. N. Ave

C88124

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88125

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2033 E. Lombard ST.; 2 WARD)REGISTERED NO. C 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Kernan(Residence in Baltimore: No. 2033 E. Lombard St.; 57 yrs., 5 mos., 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male4-COLOR OR RACE White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, Not known, 1.....

(Month)

(Day)

(Year)

7-AGE, 57

.....yrs.....mos.....ds.

If LESS than 1 day,

.....hrs. or.....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt City10-NAME OF FATHER, Anton Kernan11-BIRTHPLACE OF FATHER (State or Country) Ireland12-MAIDEN NAME OF MOTHER Elois Rehak13-BIRTHPLACE OF MOTHER (State or Country), Slavonia Coast

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mathew Kernan(Address) 326 N. Fulton

15-

SEP 12 1915

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept. 10, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26, 1915, to Sept 10, 1915,that I saw him alive on Sept 10, 1915,and that death occurred, on the date stated above, at 8:15 a m.

The CAUSE OF DEATH* was as follows:

BronchitisAcute Lung

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Bright's Disease

(Duration).....yrs.....mos.....ds.

(Signed) H. C. Thierup M. D.Sept 11, 1915. (Address) 303 E. Balt. Fr.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? 2

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy CrossDATE OF BURIAL, Sept 13, 191520-UNDERTAKER Frank Grack & SonADDRESS 1704 E. Lombard

C88125

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 C88125

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1424 N. Gilman

ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Joseph Howard Underwood Jr.

(Residence in Baltimore: No. 1424 N. Gilman

St. yrs. mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH August 31, 1915 (Month) (Day) (Year)

7-AGE yrs. mos. 12 ds. or min. 1 day, hrs. If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore Md.

10-NAME OF FATHER Joseph H. Underwood

11-BIRTHPLACE OF FATHER (State or country) Maryland

12-MAIDEN NAME OF MOTHER Mary J. Meigs

13-BIRTHPLACE OF MOTHER (State or country) New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph H. Underwood

(Address)

1424 Gilman St.

15.

SEP 12 1915

HARRY O. ANDREWS,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept. 11, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Aug 31, 1915, to Sept 11, 1915.

that I saw him alive on Sept 11, 1915, and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Auto Intoxication

Contributory (SECONDARY) Intestinal Indigestion (Duration) yrs. mos. 1 ds.

(Signed) J. Edward Cummings M. D. (Address) 2104 Garrison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Louden Park Sept 13, 1915

20-UNDERTAKER

ADDRESS

Josiah Syfer 1600 N. Market Ave.

C88126

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *14* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Elba Nicol*Residence in Baltimore: No. *1601 Linden Ave.* St.; yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *March 1, 1836*

(Month)

(Day)

(Year)

7-AGE, *79* yrs., *6* mos., *10* ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, *Maryland*

(State or Country),

10-NAME OF FATHER, *Justin Wright*11-BIRTHPLACE OF FATHER, *Ind.*

(State or Country),

12-MAIDEN NAME OF MOTHER, *Rachel Wright*13-BIRTHPLACE OF MOTHER, *Ind.*

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *G. M. Nicol*(Address) *28 S. Semmes Road*

15-

Filed *SEP. 12 1915*191... *Serial Permit 9101*

HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 11, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *9/10* 1915, to *9/11* 1915,that I saw h. *er* alive on *9/11* 1915,and that death occurred, on the date stated above, at *9:45 p.m.*

The CAUSE OF DEATH* was as follows:

Pneumonia - Following
Myocardial infarction of pericardium.
(Duration) 10 yrs., 10 mos., 10 ds.
*Accidental Fall on Floor*CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Wm. Stein*

M. D.

9/11, 1915 (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *2* ds. In *Life* State *Ind.* mos. ds.Where was disease contracted, *1601 Linden Ave*
if not at place of death?Former or usual residence *1601 Linden Ave*19-PLACE OF BURIAL OR REMOVAL, *St. Pauls Church*DATE OF BURIAL, *Sept. 12, 1915*20-UNDERTAKER, *Wm. Mitchell*ADDRESS, *1601 Linden Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *2325 East Monument* St.;yrs. *2* mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

*July**1915*

7-AGE,

2 mos.

If LESS than 1 day,hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Frank Haddaway

11-BIRTHPLACE OF FATHER (State or Country),

?

12-MAIDEN NAME OF MOTHER

?

13-BIRTHPLACE OF MOTHER (State or Country),

?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

S. Rossel

(Address).....

Johns Hopkins Hosp.

15-

Filed.....

SEP 12 1915

191.....

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 11th

(Month)

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept. 9th* 1915, to *Sept 11th* 1915, that I saw her alive on *Sept 11th* 1915, and that death occurred, on the date stated above, at *2:30 p.m.*

The CAUSE OF DEATH* was as follows:

Acute intestinal indigestion

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....

Wm. F. Power

M. D.

Sept. 11th, 1915. (Address).....*Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? *1316 East Monument St*

Former or usual residence

2325 East Monument

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*McCarmel Cemetery**Sept 13/1915*

20-UNDERTAKER

ADDRESS

Christian Miller 2834 Jefferson St

C88128

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *717 E. Biddle* St. *10* WARD)2-FULL NAME *Mary A. Guillin*(Residence in Baltimore: No. *717 E. Biddle* St. *30* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE
MARRIED, *Married*
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH *Don't know*7-AGE *43*If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Housework at home*9-BIRTHPLACE
(State or country)*Ireland*

10-NAME OF FATHER

*Thomas Clarke*11-BIRTHPLACE OF FATHER
(State or country)*Ireland*

12-MAIDEN NAME OF MOTHER

*Ann McGarry*13-BIRTHPLACE OF MOTHER
(State or country)*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Edward Guillin*(Address) *717 E. Biddle St.*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept 9, 1915*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 13, 1915* to *Sept 9, 1915*, that I saw her alive on *Sept 9, 1915*, and that death occurred, on the date stated above, at *10.15 A.m.*

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

(Duration)

yrs.

8

mos.

ds.

Contributory (SECONDARY) *Nephritis*

(Duration)

yrs.

1

mos.

ds.

(Signed) *Robert J. Green*

M. D.

Sept 11, 1915[Address] *120 1/2 Aisquith St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *St. Peter's Cemetery*DATE OF BURIAL *Sept 13th, 1915*20-UNDERTAKER *St. Margaret's. Flynn*ADDRESS *1422 Light St.*

15-

FILED

SEP 12 1915

HARRY O. ANDREWS,

Bureau Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88129

C88129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *1430 Hanover.* 23 REGISTERED NO. C
 CITY OF BALTIMORE: (No. *8* ST. *Life* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME *Michael J. Cullen*
 (Residence in Baltimore: No. *1430 Hanover St.* St. *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
 4-COLOR OR RACE, *White*
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
 6-DATE OF BIRTH, *Sept 5*, 1860
 (Month) (Day) (Year)
 7-AGE, *55* yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, *Inspector*
 (b) General nature of industry, business, or establishment in which employed (or employer), *Clerk*

9-BIRTHPLACE, (State or Country), *Matto md.*

10-NAME OF FATHER, *Michael Cullen*

11-BIRTHPLACE OF FATHER (State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER, *Mary Dolys*

13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Rose Cullen*
 (Address) *1430 Hanover St.*

15- SEP 12 1915 HARRY O. ANDREWS, Registrar.
 Filed 1915

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 10*, 1915.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 26* 1915, to *Sept 10* 1915, that I saw him alive on *Sept 10* 1915, and that death occurred, on the date stated above, at *1240 am.*

The CAUSE OF DEATH* was as follows:

Polar pneumonia
 (Duration) yrs. mos. ds. *15*

CONTRIBUTORY *Cardiac Depletion*
 (Secondary)

(Duration) yrs. mos. ds. *3*
 (Signed) *J. A. McDermott* M. D.
Sept 10, 1915. (Address) *107 E. 24th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cathedral Cemetery* DATE OF BURIAL, *Sept 13*, 1915.

20-UNDERTAKER *Margaret G. Flynn* ADDRESS *1422 Light St.*

C88130

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88130

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., 4 mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

(Month)

(Day)

(Year)

7-AGE.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-SEP 12 1915

HARRY O. ANDREWS,

Filed..... 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 11

1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

Aug 11, 1915, to Sept 11, 1915,

that I saw him alive on Sept 11, 1915,

and that death occurred, on the date stated above, at 6:15 p.m.

The CAUSE OF DEATH* was as follows:

Fatal Intoxication

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

9/11, 1915 (Address) Howard Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. ds. In the State yrs. 2 mos. ds.

Where was disease contracted, if not at place of death? 506 E 26th St.

Former or usual residence 506 E 26th St.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Western Cemetery

Sept 13, 1915

20-UNDERTAKER

ADDRESS

William Cook

502 E North Ave

C88131

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.; *16* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *825 Poplar Grove St.* St.; *33* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Jan
(Month) (Day) (Year)

7-AGE,

60
yrs. mos. ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....*Merchant*(b) General nature of industry, business, or establishment in which employed (or employer).....*unknown*9-BIRTHPLACE,
(State or Country),*Italy*

10-NAME OF FATHER,

*Don't know*11-BIRTHPLACE OF FATHER
(State or Country),*Italy*

12-MAIDEN NAME OF MOTHER

*Don't know*13-BIRTHPLACE OF MOTHER
(State or Country),*Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Palmisano*(Address) *825 Poplar Grove St.*

15-

Filed.....

191.....

HARRY O. ANDREWS,

Marial Permit. Alex. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

September 10, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *September 8, 1915*, to *September 10, 1915*, that I saw him alive on *September 10, 1915*, and that death occurred, on the date stated above, at *3 a. m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration).....*14* yrs. *14* mos. ds.CONTRIBUTORY
(Secondary)*Cholecystitis - operated*(Duration).....*about two weeks* yrs. mos. ds.(Signed).....*J. M. Vinton, Cliff* M. D.*Sept. 10, 1915* (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....*2* yrs. *2* mos. *2* ds. In the State..... yrs. mos. ds.Where was disease contracted, if not at place of death? *unknown*

Former or usual residence

825 Poplar Grove St.

19-PLACE OF BURIAL OR REMOVAL,

River Cathedral

DATE OF BURIAL,

Sept. 10, 1915

20-UNDERTAKER

John A. Howard & Son

ADDRESS

Bank

C88132

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

C88132

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

815 W Lombard

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Fauces Clinchell

(Residence in Baltimore: No.

815 W Lombard St

St.: — yrs. — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female white

4-COLOR OR RACE.

5-SINGLE
MARRIED.
WIDOWED.
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH.

April

23

1915

(Month)

(Day)

(Year)

7-AGE.

4 yrs. 19 mos. 19 da.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

U.S.

10-NAME OF FATHER,

Joseph Clinchell

11-BIRTHPLACE OF FATHER
(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Mary Myers

13-BIRTHPLACE OF MOTHER
(State or Country).

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. J. Rheinhold

(Address)

815 W Lombard St

15-

SEP 12 1915

HARRY O. ANDREWS,

Filed

MAY 13 1916

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 11, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 4 1915, to Sept 11 1915

that I saw him alive on Sept 10 1915

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Foster Intestinal Indigestion

(Duration) yrs. mos. 12 da.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. 1 da.

(Signed)

E. W. W. W. W. M. D.

Sept 11/15 1915 (Address) 24 W. Fellows St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Peter's Cemetery

Sep 12, 1915

20-UNDERTAKER

ADDRESS

Geo. Leimbach & Son

647 W. Pratt St

C88133

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 C88133
REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 15 E 7th Ave. St. 23 WARD)

2-FULL NAME Carrie Dabel Lowman

(Residence in Baltimore: No. 15 E 7th Ave. St. 11 yrs. - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(If write the word)

Widow

6-DATE OF BIRTH

August 19, 1872

(Month)

(Day)

(Year)

7-AGE

43

yrs.

- mos.

22 ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

Maryland

10-NAME OF
FATHER

Frank Albert

PARENTS

11-BIRTHPLACE
OF FATHER
(State or country)

Maryland

12-MAIDEN NAME
OF MOTHER

Nancy King

13-BIRTHPLACE
OF MOTHER
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Helen Craig

(Address)

17th Street

15-

Filed

SEP 12 1915

191

HARRY O. ANDREWS

Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 10, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

August 10, 1915, to Sept 10, 1915.

that I saw her alive on Sept 10, 1915.

and that death occurred, on the date stated above, at 11:42 am.

The CAUSE OF DEATH* was as follows:

Nephritis

"History"

(Duration)

yrs.

2

mos.

ds.

Contributory
(SECONDARY)

Valvular Heart Disease

(Signed)

Sept 10, 1915

(Address)

1203 Light

M. D.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Cedar Hill

DATE OF BURIAL

Sept 12, 1915

20-UNDERTAKER

F. A. Krause

ADDRESS

703 Hanover

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88134

CERTIFICATE OF DEATH.

30

C88134

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1)

Mercy Hospital St. 1

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Elizabeth Piegel

Residence in Baltimore: No.

616 So. Carley St.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

Single

6-DATE OF BIRTH

Oct 1, 1914

(Month)

(Day)

(Year)

7-AGE

11 mos. 9 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

"

9-BIRTHPLACE, (State or Country),

Md.

10-NAME OF FATHER,

George Piegel

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Alice Rich

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Reed Mercy Hosp.

(Address)

Calvert St.

15-

SEP 12 1915

Filed

191

HARRY O. ANDERSON

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept. 10, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

Sept. 9, 1915, to Sept. 10, 1915

that I saw him alive on Sept. 10, 1915

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration)

One week

CONTRIBUTORY (Secondary)

(Duration)

One week

(Signature)

Edward J. Smith M. D.

(Address)

1015 (Address) Mercy Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

616 So. Carley St.

Former or usual residence

616 So. Carley St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Mt Carmel

Sept. 13, 1915

20-UNDERTAKER

ADDRESS

H. Sander & Sons

1210 Flt

C88135

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 C88135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2638 Lakewood St.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Augusta Arens

(Residence in Baltimore: No.

2638 Lakewood Ave St.

65 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH.

July 16th, 1838

(Month)

(Day)

(Year)

7-AGE,

77 yrs. 1 mos. 23 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Not Known

11-BIRTHPLACE OF FATHER (State or Country),

Not Known

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER (State or Country),

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Annelia Mills

(Address)

823 S.bury St.

15-

HARRY O. ANDREWS,

Filed SEP 12 1915 1915

Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 9th, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1915, to Sept 9, 1915, that I saw her alive on Sept 9, 1915, and that death occurred, on the date stated above, at 5:25 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (Pyloric) (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Cachexia

(Duration) ... yrs. ... mos. ... ds.

(Signed)

W. J. Meary M. D.

Sept 9, 1915 (Address) 839 S. E. Edwards

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Trinity Cemetery

DATE OF BURIAL,

Sept 13, 1915

20-UNDERTAKER

H. Sanders & Sons

ADDRESS

1710 N. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88136

C88136

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2123 Mayer ST.: 6 WARD)FULL NAME Anna Sperber(Residence in Baltimore: No. 2123 Mayer St.: 50 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed6-DATE OF BIRTH, Jan 16, 1871
(Month) (Day) (Year)7-AGE, 74 yrs., 7 mos., 25 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House work
(b) General nature of industry, business, or establishment in which employed (or employer). at home9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, not known11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER not known13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Laughlin(Address) 2317 E. Madison St.

15-SEP 12 1915 HARRY O. ANDREWS

Filed , 1915 Marial Permit Office

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 28, 1915, to Sept 19, 1915, that I saw her alive on Sept 19, 1915, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.(Signed) M. D. , 1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? Former or usual residence 19-PLACE OF BURIAL OR REMOVAL, St. Matthews DATE OF BURIAL, Sept 13 191520-UNDERTAKER St. Sander & Sons ADDRESS 1710 Flat St

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *1304 Fremont Ave* St. *15* WARD)2-FULL NAME *Mollie Anna Dempsey*(Residence in Baltimore: No. *1304 Fremont Ave* St. *15* yrs. *13* mos. *10* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE MARRIED *Married* WIDOWED OR DIVORCED (Write the word)6-DATE OF BIRTH *October 1, 1862* (Month) (Day) (Year)7-AGE *52 yrs. 11 mos. 10 ds.* or min. 1 day, hrs. min.?8-OCCUPATION (a) Trade, profession or particular kind of work *House work* (b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE (State or country) *Thurmont Md.*10-NAME OF FATHER *Robert L. Melhide*11-BIRTHPLACE OF FATHER (State or country) *Don't know*12-MAIDEN NAME OF MOTHER *Annula James*13-BIRTHPLACE OF MOTHER (State or country) *Don't know*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Bertha Kelley*(Address) *1304 Fremont Ave.*

15-SEP 12 1915 HARRY O. ANDREWS, Serial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept 10, 1915* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 1, 1915*, to *Sept 10, 1915*, that I saw her alive on *Sept 10, 1915*, and that death occurred, on the date stated above, at *10.05 a.m.*

The CAUSE OF DEATH* was as follows:

*Tuberc Pneumonia*Contributory (SECONDARY) *Cardiac Asthenia* (Duration) yrs. mos. *9* ds.(Signed) *B. William Tier* M. D. *Sept 10, 1915* [Address] *1228 Penna St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Linden Park Cemetery* DATE OF BURIAL *Sept 13, 1915*20-UNDERTAKER *Chas. G. Black* ADDRESS *1201 W. Mulberry St.*

C88138

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

150 C88138
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 145 E. 30th ST. 9 WARD)
2-FULL NAME William George Goldstraw
(Residence in Baltimore: No. 145 E. 30th St. yrs. 5 mos. 7 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH April 5th, 1915 (Month) (Day) (Year)

7-AGE 5 yrs. 7 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Baltimore - Md.

10-NAME OF FATHER William Goldstraw

11-BIRTHPLACE OF FATHER (State or country) England

12-MAIDEN NAME OF MOTHER Clara Larkin

13-BIRTHPLACE OF MOTHER (State or country) Baltimore - Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Goldstraw
(Address) 745 E. 30th St.

15 SEP 12 1915

HARRY O. ANDREWS,
Morial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH September 12, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 30, 1915, to Sept 12, 1915, that I saw him alive on August 30, 1915, and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:
Congenital heart diseaseContributory Premature birth (Duration) yrs. 5 mos. 7 ds.
(SECONDARY)(Signed) Bertha E. Tappan M. D.
Sept 12, 1915 (Address) 2733 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cemetery

Sept 13, 1915

20-UNDERTAKER

ADDRESS

George Schelling & Sons 1126 E. Monument St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88139

CERTIFICATE OF DEATH.

28
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

1939 Edmonson ave

ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Frances N. Penn

(Residence in Baltimore: No.

1939 Edmonson ave

St.; 30 yrs., 8 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH.

January 16th, 1885
(Month) (Day) (Year)

7-AGE.

30 yrs., 8 mos., 26 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Clerk
Wm. Bros.9-BIRTHPLACE,
(State or Country),

Baltimore Md

10-NAME OF FATHER,

Richard J Penn

11-BIRTHPLACE OF FATHER
(State or Country),

England

12-MAIDEN NAME OF MOTHER

Susan A. Young

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Margaret R Penn

(Address).....

1913 Edmonson ave

15-

HARRY O. ANDREWS,

Filed

191

Serial 30111

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sep. 11, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sep 3 1915, to Sep 11 1915,

that I saw him alive on Sep 10 1915,

and that death occurred, on the date stated above, at 12:22 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) 8 yrs., 11 mos., 1 ds.CONTRIBUTORY
(Secondary)

(Duration) 1 yr., 11 mos., 1 ds.

(Signed) Walter W. White M. D.

Sep 11, 1915. (Address) 1101 4th Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

Sept 13th, 1915.

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 Monument

C88140

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88140

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.

826 S. Milton Ave

ST.

WARD)

2-FULL NAME

William Knach

(Knach)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No.

826 S. Milton Ave

St.: yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Single

6-DATE OF BIRTH,

Feb

11

1915

(Month)

(Day)

(Year)

7-AGE,

7 yrs. 7 mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

Wm J. Knach

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Larrie Marziska

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm J. Knach

(Address)

826 S. Milton Ave

15-

Filed

191

HARRY O. ANDREWS

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September

10

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said
(Inquest, au-topsy or inquiry.) find that said deceased came to death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Lethal Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. W. Jones M. D.
(Coroner.)

Sept 11, 1915 (Address) 3116 E. Journal St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Sept. 13, 1915

20-UNDERTAKER

Hendell Lippel Son

ADDRESS

330 S. Bond St

C88141

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88141

1 PLACE OF DEATH

64
REGISTERED NO. C.....CITY OF BALTIMORE: (No. *1110 S. Kenwood Ave* ST. *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary David*(Residence in Baltimore: No. *1110 S. Kenwood Ave* St. *23* yrs. *23* mos. *23* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *female*4-COLOR OR RACE *white*5-SINGLE
MARRIED *Married*
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH *Aug 20, 1866*7-AGE *49* yrs. *20* mos. *20* ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Housewife*9-BIRTHPLACE
(State or country) *Austria*10-NAME OF FATHER *Michael Preuer*11-BIRTHPLACE OF FATHER
(State or country) *Austria*12-MAIDEN NAME OF MOTHER *Katie Preuer*13-BIRTHPLACE OF MOTHER
(State or country) *Austria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *John David*(Address) *1110 S. Kenwood Ave*

15-

Filed *SEP 12 1915*

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept 11, 1915*17-I HEREBY CERTIFY, That I attended deceased from *Sept 6, 1915*, to, *Sept 11, 1915*that I saw *her* alive on *10* *1915*, and that death occurred, on the date stated above, at *12:30* m.

The CAUSE OF DEATH* was as follows:

*Cerebral Hemorrhage*Contributory
(SECONDARY) *Coma*(Signed) *Chas. Keen**Sept 11, 1915* [Address] *408 S. Pratt St. Bk. Ave*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *23* yrs. *23* mos. *23* ds. In the State *23* yrs. *23* mos. *23* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *St. Stanislaus Church*DATE OF BURIAL *Sept 13, 1915*20-UNDERTAKER *Stephen F. Frachonick*ADDRESS *1017 S. Kenwood Ave*

C88142

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88142

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 34 N. Curley

ST. 6

WARD)

REGISTERED No. C 79

2-FULL NAME

Barbara Klinker

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 34 N. Curley

St. 6

Sept 11, 1915

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female	4-COLOR OR RACE, White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow
6-DATE OF BIRTH, Sept 13, 1867 (Month) (Day) (Year)		
7-AGE, 47 yrs. 11 mos. 29 ds.		8-If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,
(State or Country).

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

John Reithing Schoepfer

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Catherine E. Schmidtbleicher

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Catherine Schmidt

(Address)

301 S. Pulaski St.

15-

SEP 12 1915

HARRY O. ANDREWS,

Filed

1915

Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH,

Sept 11, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.
(Signed) ... M. D.
(Coroner.)
(Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place ... In the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

London Park Cemetery

SEP 13 1915

20-UNDERTAKER

ADDRESS

Geo A. Gerbig

Baltimore, Md.

C88143

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88143

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1812 Dover St.,

CITY OF BALTIMORE: (No. 1812 Dover

ST., 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 10.)

2-FULL NAME Baby Smith

(Residence in Baltimore: No. 1812 Dover St.,

St.; yrs., — mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
 4-COLOR OR RACE, White
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single
 6-DATE OF BIRTH, 8 - 23, 1915
 (Month) (Day) (Year)
 7-AGE, yrs. mos. 28 ds.
 If LESS than 1 day, hrs. or min.

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md. (City)

10-NAME OF FATHER, George Smith
 11-BIRTHPLACE OF FATHER (State or Country), Md.
 12-MAIDEN NAME OF MOTHER, Mary Mondt
 13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Smith

(Address) 1812 Dover St.

15-SEP 12 1915 HARRY O. ANDREWS,

Filed, 191. Burial Permit. 01001 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep 11, 1915
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 23, 1915, to Sep 11, 1915, that I saw her alive on Aug 23, 1915, and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:
 Congenital Deletasia

(Duration) 0 yrs. 0 mos. 28 ds.

CONTRIBUTORY... Prematurity
 (Secondary)

(Duration) 0 yrs. 0 mos. 28 ds.

(Signed) P. L. Rush M. D.

4-1-2, 1915 (Address) University Hall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Peters Cemetery Sep 11, 1915

20-UNDERTAKER ADDRESS

Geo. A. Gerby Balt. & P. & M.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C88144

CERTIFICATE OF DEATH

C88144

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

Tarrison & Oakford Ave

ST.

15

WARD)

FULL NAME

Mary Elizabeth Oakford

(Residence in Baltimore: No.

Tarrison & Oakford Ave

St.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and list out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

6-DATE OF BIRTH

July

9

1873

(Month)

(Day)

(Year)

7-AGE

42

2

2

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

W. Va.

PARENTS

10-NAME OF FATHER

Charles Callaway

11-BIRTHPLACE OF FATHER
(State or country)

Va

12-MAIDEN NAME OF MOTHER

King

13-BIRTHPLACE OF MOTHER
(State or country)

Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Hullehan

(Address)

Tarrison & Oakford Ave

15.

SEP 12 1915

HARRY O. ANDREWS,
Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

September

11

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Tarrison, 1912, to, September 1915,

that I saw her alive on September 11, 1915,

and that death occurred, on the date stated above, at 1:10 A.M.

The CAUSE OF DEATH* was as follows:

Heart's Disease

(Duration) 4 yrs. mos. ds.

Contributory
(SECONDARY)

Congestion of the lungs

(Duration) yrs. mos. ds.

(Signed) D. H. A. M. D.

12. 11. 1915 (Address) 1614 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Grind Ridge Cem

DATE OF BURIAL

Sept 13, 1915

20-UNDERTAKER

Chas. E. Spang

ADDRESS

802 Madison Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88145

C88145

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *109*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *913 E. Madison St.*)yrs. *9* mos. *7* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) *Single*

6-DATE OF BIRTH.

Dec. 11, 1914

(Month)

(Day)

(Year)

7-AGE.

9 yrs. *1* mos. *1* da.

If LESS than 1 day.

hrs. or mins.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country).*Balto., Md.*

10-NAME OF FATHER.

*Abraham Slusky*11-BIRTHPLACE OF FATHER
(State or Country).*Russia*

12-MAIDEN NAME OF MOTHER

*Sarah Ellovish*13-BIRTHPLACE OF MOTHER
(State or Country).*U.S. a. Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. Lewis

(Address)

1419 E. Baltimore St.

15-

SEP 13 1915

ROBERT KRAUTER,

101. BAL. H. L. PERMIT. CLERK.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH.

September 12, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept. 9* 1915, to *Sept. 12* 1915, that I saw him alive on *Sept. 12* 1915, and that death occurred, on the date stated above, at *1050th*.

The CAUSE OF DEATH* was as follows:

*Ulceration of bowel
following Intestinal
Tuberculosis.*
(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Chemia (Duration) yrs. mos. ds.Signed) *W. H. H. (Starr)*
Sept. 12, 1915 (Address) *Church Home*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *at home*

Former or usual residence

913 E. Madison St.

19-PLACE OF BURIAL OR REMOVAL.

Hebrew Cemetery

DATE OF BURIAL.

9/13, 1915

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Baltimore St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *643 W. Lombard* ST.: *4* WARD)2-FULL NAME *Michael Zipprian*(Residence in Baltimore: No. *643 W. Lombard* St.: *51* yrs., *10* mos., *3* ds.)REGISTERED NO. C. *88146*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married* (Write the word.)6-DATE OF BIRTH, *Nov 8*, 18*83* (Month) (Day) (Year)7-AGE, *51* yrs., *10* mos., *3* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Barber* (b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Balto. Md.*10-NAME OF FATHER, *Geo. Zipprian*11-BIRTHPLACE OF FATHER (State or Country), *Balto. Md.*12-MAIDEN NAME OF MOTHER, *Theresa Krustberg*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Fiddley*(Address) *1103 Columbia*

15-SEP 13 1915 ROBERT KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DAYS OF DEATH, *September 11*, 191*5* (Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *August 15* 191*5*, to *Sept 11* 191*5*, that I saw him alive on *Sept 11* 191*5*, and that death occurred, on the date stated above, at *6 P* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Duration) *1* yrs., mos., ds.

CONTRIBUTORY (Secondary).....

(Signed) *T. A. Dornier* M. D. *Sept 11*, 191*5* (Address) *107 S. W. 2nd*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Lorraine Cemetery* DATE OF BURIAL, *Sept 14*, 191*5*20-UNDERTAKER, *Jas. Piquetson* ADDRESS, *1000 S. Paca*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88147

CERTIFICATE OF DEATH.

92
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *921 N. Fulton av* ST. *17*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *921 N. Fulton av*)St. *17* mos. (da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Feb 11, 1861
(Month) (Day) (Year)

7-AGE,

54 yrs. *6* mos. *29* ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *Wholesale*
(b) General nature of industry, business, or establishment in which employed (or employer)... *Beef salesman*

9-BIRTHPLACE, (State or Country),

Balti.
Maryland

10-NAME OF FATHER,

Jas A. Rosenberg

11-BIRTHPLACE OF FATHER (State or Country),

Na

12-MAIDEN NAME OF MOTHER

Virginia M. Thomas

13-BIRTHPLACE OF MOTHER (State or Country),

Na

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... *Ella C. Rosenberg*(Address)... *921 N. Fulton av*

15-

SEP 13 1915 ROBERT J. KRAUTH
Filed... 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sep 10, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sep 1st* 1915, to *Sep 10* 1915, that I saw him alive on *Sep 10* 1915, and that death occurred, on the date stated above, at *10³⁰* m. The CAUSE OF DEATH* was as follows:*Lobar Pneumonia**10 days* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Heart failure
24 hours (Duration) yrs. mos. ds.
(Signed) *John F. Hanger* M. D.*Sep 12*, 1915 (Address) *1000 Edmonstone av*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cem

DATE OF BURIAL,

Sep 12, 1915

20-UNDERTAKER

Wm. J. Dickerson

ADDRESS

North Perry

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9)

2-FULL NAME

(Residence in Baltimore: No. 217 President St.)REGISTERED NO. C 45

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

unknown, 1869
(Month) (Day) (Year)

7-AGE,

46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer). General9-BIRTHPLACE, (State or Country), Greece10-NAME OF FATHER, Stephen Marvis11-BIRTHPLACE OF FATHER (State or Country), Greece12-MAIDEN NAME OF MOTHER Not Known13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Moll(Address) 1710 Fleet St.

15-

SEP 13 1915

ROBERT A. KRAUTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 11, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1915 to Sept. 11, 1915, that I saw him alive on Sept. 11, 1915 and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lung
Went down (Duration) mos. ds.

CONTRIBUTORY (Secondary)

Shock following (Duration) 40 hours ds.
(Signed) John M. D.
Sept. 13, 1915 (Address) Mersey Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 13 ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? Don't knowFormer or usual residence 217 President St.

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn Cem.

DATE OF BURIAL,

Sept 13, 1915

20-UNDERTAKER

J. Sander & Sons

ADDRESS

1710 Fleet St.

C88149

Catherine Fleming
HEALTH DEPARTMENT—CITY OF BALTIMORE

C88149

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. *Johns Hopkins Hospital* ST. *10* WARD) REGISTERED NO. C
2-FULL NAME *Catherine Fleming*
(Residence in Baltimore: No. *721 Kirch Court* St.; *3* yrs., *3* mos., *3* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH *June 5th*, 1915.
(Month) (Day) (Year)
7-AGE, *3* yrs., *3* mos., *3* ds. If LESS than 1 day,hrs. or....min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*
10-NAME OF FATHER, *John Fleming*
11-BIRTHPLACE OF FATHER (State or Country), *Virginia*
12-MAIDEN NAME OF MOTHER, *Susan Whitney*
13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *S. Ross*
(Address) *Johns Hopkins Hosp.*

5-SEP 13 1915
6-REGISTRAR, *Robert Krauth*
7-DEPUTY REGISTRAR, *Robert Krauth*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 11th*, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 4th* 1915, to *Sept. 11th* 1915, that I saw her alive on *Sept. 11th* 1915, and that death occurred, on the date stated above, at *7:30 p.m.*

The CAUSE OF DEATH* was as follows:

Pneumonia, acute Lobar.
(Duration) yrs. mos. *14* ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *Edward A. Boyd* M. D.
Sept. 11th, 1915. (Address) *Johns Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *7* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *Johns Hopkins Hosp.*

Former or usual residence *721 Kirch Court, Balto.*

19-PLACE OF BURIAL OR REMOVAL.

Pauline Cemetery DATE OF BURIAL, *Sept. 13, 1915.*

20-UNDERTAKER, *Robert A. Elliott* ADDRESS *506 Rogers Ave.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 Jackson St ST.: 24 WARD)2-FULL NAME Thos. Jos. Bailey

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1736 Jackson St. St.: 24 yrs. 4 mos. 6 da.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)

DATE OF BIRTH. May 6, 1915
(Month) (Day) (Year)

AGE. 4 yrs. 6 mos. 6 da. 10-LESS than 1 day, 6 hrs. or 6 min.?

OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, Thos. Bailey11-BIRTHPLACE OF FATHER (State or Country), Baltimore12-MAIDEN NAME OF MOTHER, Mrs. Scott13-BIRTHPLACE OF MOTHER (State or Country), Virginia

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Jos. Bailey(Address) 1736 Jackson St.

5-SEP. 13. 1915

ROBERT KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 5th 1915, to Sept. 13th 1915,
that I saw him alive on Sept. 5th 1915,
and that death occurred, on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

ileo-colitis
(Duration) 2 yrs. 2 mos. 6 da.

CONTRIBUTORY (Secondary)

(Signed) O.B. Fowler M. D.
Sept. 13, 1915 (Address) 1432 William St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs. 6 mos. 6 da. In the State 4 yrs. 6 mos. 6 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Finnepitton Va. DATE OF BURIAL, Sept 13 191520-UNDERTAKER, Wm. J. Taylor ADDRESS, 318 Light St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88151

C88151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1028 Greenmount Ave* 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1028 Greenmount Ave* St.: *Life* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED, *Single* (Write the word)

DATE OF BIRTH, *June 27*, 1911 (Month) (Day) (Year)

AGE, *4* yrs., *2* mos., *14* ds. If LESS than 1 day, hrs. or min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work, *None*

(b) General nature of industry, business, or establishment in which employed (or employer),

BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Mr C Zick*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER, *Anna J. Kenealy*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Mr C Zick*(Address), *1028 Greenmount Ave*

5-

SEP 13 1915

Filed

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 12*, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 10* 1915, to *Sept 12* 1915, that I saw her alive on *Sept 12* 1915, and that death occurred, on the date stated above, at *5:30* pm.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(Duration).... yrs. mos. ds.

CONTRIBUTORY (Secondary) *acute dilatation*

J. Heart (Duration).... yrs. mos. ds.

(Signed) *James M. Benton* M. D.

Sept 12 1915 (Address) *700 E. Chase St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *New Cathedral Ave*DATE OF BURIAL, *Sept 13*, 191520-UNDERTAKER, *H. C. Wiedefeld*ADDRESS, *914 Greenmount Ave.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88152

CERTIFICATE OF DEATH.

104 C88152
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 41 E York

ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Sena Svitich

(Residence in Baltimore: No. 41 E. York

St.; \ yrs., 5 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

April 4, 1915
(Month) (Day) (Year)

7-AGE,

5 yrs., 5 mos., 8 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Dry air

9-BIRTHPLACE, (State or Country),

Maryland Bk

10-NAME OF FATHER,

Max Svitich

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Barbara Nikolaichis

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Svitich

(Address) 41 E. York St.

SEP 13 1915

RAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept. 12, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 12, 1915, to Sept. 12, 1915, that I saw her alive on Sept. 12, 1915, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

acute gastro-enteric intoxication

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(convulsions)

(Duration) yrs. mos. ds.

(Signed) J. S. Rauter M. D.

Sept. 12, 1915 (Address) 121 W. Lee St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

St. Stanislawas

DATE OF BURIAL,

Sept. 13, 1915

20-UNDERTAKER

John Grieblich, 500 S. Lucas St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88153

C88153

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *413 S. High St* St.; *4* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

*white*5-SINGLE, *widowed*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

Sept 28, 1860
(Month) (Day) (Year)

7-AGE

*54 yrs. 11 mos. 13 ds.*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Sailor*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE.

(State or Country), *Italy*10-NAME OF FATHER, *Gaspara Aucca*

11-BIRTHPLACE OF FATHER

(State or Country), *Italy*

12-MAIDEN NAME OF MOTHER

Emmetta Disporo

13-BIRTHPLACE OF MOTHER

(State or Country), *Italy*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louis Xaparra*(Address) *413 S. High St*

5-

SEP 13 1915

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 11, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 24, 1915*, to *Sept 11, 1915*, that I saw him alive on *Sept 11, 1915*, and that death occurred, on the date stated above, at *7.10 a.m.*

The CAUSE OF DEATH* was as follows:

Phthirus Girolis of liver
(Duration) *4* yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Signed) *Edward P. Smith* M. D.
Sept 13, 1915. (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. *1* mos. *20* ds. In the *4* State *MD* yrs. — mos. — ds.Where was disease contracted, if not at place of death? *at home*

Former or usual residence

413 S. High St

19-PLACE OF BURIAL OR REMOVAL,

St. Vincent

DATE OF BURIAL,

Sept 13, 1915

20-UNDERTAKER

Wendell Lippertson

ADDRESS

330 S. Bond

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88154

C88154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *(Gelston Heights)*
 CITY OF BALTIMORE: (No. *Private Home for Feeble-minded* ST.; *16* WARD)
 2-FULL NAME *Emily G. Carpenter*
 (Residence in Baltimore: No. *Gelston Heights* St.; *Lifetime* yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX. *Female* 4-COLOR OR RACE, *White* 5-STATUS, *Widowed*
 (MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
 DATE OF BIRTH *August 10, 1834*
 (Month) (Day) (Year)
 AGE, *81* yrs., *1* mos., *3* ds. If LESS than 1 day, ...hrs. or ...min.
 OCCUPATION:
 (a) Trade, profession, or particular kind of work. *none*
 (b) General nature of industry, business, or establishment in which employed (or employer). *none*
 BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *Columbus E. Cook*
 11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*
 12-MAIDEN NAME OF MOTHER, *Catherine E. Gaffney*
 13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *S. J. Fort M. D.*
 (Address) *200 Sta. S. Balto. Md.*

5-SEP 13 1915 ROBERT KRAUTER,
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *September 12, 1915*
 (Month) (Day) (Year)
 17- I HEREBY CERTIFY, That I attended deceased from *Oct 26, 1908*, to *Sept 12, 1915*, that I saw her alive on *Sept 11th, 1915*, and that death occurred, on the date stated above, at *2* (2) m.
 The CAUSE OF DEATH* was as follows:
Senility with cerebral hemorrhage
 (Duration) yrs. *2* mos. *1* week
 CONTRIBUTORY (Secondary) *Hemiplegia*
 (Duration) yrs. *2* mos. *1* week
 (Signed) *S. J. Fort* M. D.
Sept 12, 1915 (Address) *200 Sta. S. Balto. Md.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
 At place of death *4* yrs. *10* mos. *28* ds. In the *Md.* State *Lifetime* yrs. mos. ds.
 Where was disease contracted, if not at place of death? *at place of death*
 Former or usual residence *Baltimore*

19-PLACE OF BURIAL OR REMOVAL, *London Park City* DATE OF BURIAL, *Sept. 14, 1915*
 20-UNDERTAKER, *Stewart Mowen Co* ADDRESS *108 W. North Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88153

CERTIFICATE OF DEATH.

108
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1734 N. Calvert St.; 54 yrs., 6 mos., 29 da.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX,

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Single

DATE OF BIRTH,

Feb. 14, 1861
(Month) (Day) (Year)

AGE,

54 yrs., 6 mos., 29 da.If LESS than 1 day,
....hrs. or....min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Clerk in Court
Register of WillsBIRTHPLACE,
(State or Country),Baltimore Md.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

Sep 131915Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 12, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 11 1915, to Sept 12 1915,that I saw him alive on Sept 12 1915,and that death occurred, on the date stated above, at 445 An.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis

(Duration).... yrs.... mos.... da.

CONTRIBUTORY
(Secondary)

(Duration).... yrs.... mos.... da.

(Signed)

Sept 12, 1915 (Address) St. Joseph's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 da. In the State 55 yrs. mos. da.Where was disease contracted, if not at place of death? 1734 N. Calvert StFormer or usual residence 1734 N. Calvert

19-PLACE OF BURIAL OR REMOVAL,

Mt Olive Cemetery

20-UNDERTAKER

Joseph B. Cook

DATE OF BURIAL,

Sept 14, 1915

ADDRESS

1003 West
Baltimore Md.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C88156

CERTIFICATE OF DEATH

104 C88156

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs. 4 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

May

27

1870

(Month)

(Day)

(Year)

7-AGE

45

yrs.

3

mos.

16

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Chief Engineer Emerson Hotel

9-BIRTHPLACE

(State or country)

Bath, Maine

10-NAME OF FATHER

Patrick H Olyp

11-BIRTHPLACE OF FATHER

(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Marie E Golden

13-BIRTHPLACE OF MOTHER

(State or country)

Bath, Maine

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

SER 13 1915

HARRY O. ANDERSON

Serial Permit Officer

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September 13th, 1915.

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

3 PM Sep 12th, 1915, to 1-10 AM Sep 13th, 1915.that I saw him alive on September 13th, 1915.

and that death occurred, on the date stated above, at 1-10 A. M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.

(Duration)

13 Hours,

Contributory (SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

D.W. Cather

M. D.

Sep 13, 1915 (Address) 1636 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

at 1615 E. Baltimore 4 mos 22 days

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hall River Mass

Sept 14, 1915

20-UNDERTAKER

ADDRESS

Henry W. Jenkins Soas Co W. Puller + Orchard

C88158

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88158

CERTIFICATE OF DEATH.

X 169

PLACE OF DEATH

CITY OF BALTIMORE (No. *Burles Bay Ind*)ST. *B* WARD)

REGISTERED NO. C

2-FULL NAME

Antonio Alphonso

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *None*)

St.; yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Not Known, 1889.
(Month) (Day) (Year)

7-AGE,

26 yrs. — mos. — ds.

10 LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Seaman**S.S.*

9-BIRTHPLACE, (State or Country),

Portugal

10-NAME OF FATHER,

Not Known

11-BIRTHPLACE OF FATHER (State or Country),

Not Known

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER (State or Country),

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Seldon Boudillier**Capt S.S. Transportation*
(Address)

15-

SEP 13 1915

Filed....., 191

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....
(Inquest, au-*inquiry* and that said deceased came to death on the day stated above.
(topsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... M. D.

(Coroner)

Sept 13, 1915; (Address) *316 O'Donnell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Living Cemetery**Sept 13 1915*

20-UNDERTAKER

ADDRESS

*Christa Miller**2530 Jefferson St.*

M 1922

C88159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. _____ ST. _____ WARD _____)

FULL NAME

Residence in Baltimore: No. _____ St. _____ yds. _____ mo. _____ ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and report No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX.

Female

4-COLOR OR RACE.

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

DATE OF BIRTH.

Unknown

(Month)

(Day)

(Year)

AGE.

29

yrs.

mos.

ds.

IF LESS than 1 day,

hrs. or min.

OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Lawyer

BIRTHPLACE.

(State or Country).

Md Balt

10-NAME OF FATHER.

William Peter

11-BIRTHPLACE OF FATHER

(State or Country).

Md

12-MAIDEN NAME OF MOTHER

Maggie

13-BIRTHPLACE OF MOTHER

(State or Country).

Md

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Charles B Jones

(Address)

235 N Pine St

SEP 14 1915

BIRTHAL BUREAU

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

September

(Month)

63, 1915

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 6 1915, to Sept 13 1915,

that I saw her alive on Sept 13 1915,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary)

Cancer of Pericarditis

(Duration) 2 yrs. 3 mos. 3 ds.

(Signed) C. W. Jones M. D.

Sept 13 1915 (Address) Md Gen'l H of

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. 7 mos. 7 ds. In the State 7 yrs. 7 mos. 7 ds.

Where was disease contracted, if not at place of death? 7

Former or usual residence 561 W. Hoffman St.

19-PLACE OF BURIAL OR REMOVAL.

Baltimore

DATE OF BURIAL.

Sept 14 1915

20-UNDERTAKER

Charles B Jones

ADDRESS

1118 N. Saratoga

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 CP Central Ave. 5 WARD)

REGISTERED NO. C

FULL NAME Elizabeth Cole

Residence in Baltimore: No. 535 CP Central Ave. St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX.

4-COLOR OR RACE,

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

DATE OF BIRTH,

AGE,

IF LESS than 1 day,

OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

BIRTHPLACE,

(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

5-

Filed.

SEP 14 1915

ROBERT

KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

August 30 1915, to Sept 13 1915,

that I saw her alive on Sept 13 1915,

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Sept 13 1915 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Albert Kennard M. D.

Sept 13 1915 (Address) 708 E. 12th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Skelburn Cemetery

Sept 16 1915

20-UNDERTAKER

ADDRESS

Charles B Jones

1118 M St

C88161

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88161

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 335 D. Mount St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Russell Mc Cabe(Residence in Baltimore: No. 335 D. Mount St.; — yrs. 3 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE white 5-SINGLE single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH March 25, 1915
(Month) (Day) (Year)7-AGE — yrs. 5 mos. 19 ds. or min.?
If LESS than 1 day, — hrs.8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
None9-BIRTHPLACE (State or country) Balto CityPARENTS
10-NAME OF FATHER Wm. Hill Mc Cabe
11-BIRTHPLACE OF FATHER (State or country) Balto City
12-MAIDEN NAME OF MOTHER Effie M. Kelly
13-BIRTHPLACE OF MOTHER (State or country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. H. Mc Cabe
(Address) 335 S. Mount St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept. 13, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 8, 1915, to Sept 13, 1915, that I saw him alive on Sept 13, 1915, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

TyphoidContributory (SECONDARY) Gastro Enteritis
(Duration) yrs. mos. ds.
(Signed) Wm. J. F. Blaney M.D.
Sept 15, 1915 [Address] 110 S. E. Avenue
(Duration) yrs. mos. ds.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL 9/15, 191520-UNDERTAKER Robt. Brooks & Son ADDRESS S. E. Cor Calhoun & Hollins

15- SEP 14 1915

ROBERT KRAUTH
BURIAL PERMIT CLERK
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88162

C88162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1719 W. Lombard* ST. *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1719 W. Lombard* St.; *67* yrs., *5* mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX

Male

COLOR OR RACE

White

SINGLE, MARRIED, WIDOWED, OR DIVORCED

Married
(Write the word.)

DATE OF BIRTH

April *7*, *1848*
(Month) (Day) (Year)

AGE

67 yrs. *5* mos. *3* ds.

If LESS than 1 day,

...hrs. or...min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Bank
Watchman

BIRTHPLACE, (State or Country)

Ireland

10-NAME OF FATHER

John Conroy

11-BIRTHPLACE OF FATHER (State or Country)

Ireland

12-MAIDEN NAME OF MOTHER

Mary Murphy

13-BIRTHPLACE OF MOTHER (State or Country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Conroy Jr.
(Address) *1719 W. Lombard*

SEP 14 1915

ROBERT KRAUTH

Filed..... 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept *10*, *1915*
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Aug 1* *1915*, to *Sept 10* *1915*, that I saw him alive on *Sept 10* *1915*, and that death occurred, on the date stated above, at *7* m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis
peritonitis
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Signed) *Walter A. Cox* M. D.
9.10, *1915* (Address) *5215 Fulton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

Cathedral

DATE OF BURIAL

9/15/15

20-UNDERTAKER

Geo. Stanley Tuller & Son

ADDRESS

C88163

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88163

CERTIFICATE OF DEATH

28

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 717 Druid Hill Ave. ST. 11. WARD)

2-FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number and RH out No. 18.)

(Residence in Baltimore: No. 717 Druid Hill Ave. St. 11. yrs. mos. ds.)

Huron to St. Charles Ave. as Burdie Thompson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

10-DATE OF DEATH

6-DATE OF BIRTH

7-AGE

If LESS than

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on Sept 11, 1915, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary
(note) This pt was not treated by me. I saw him about 10 days prior to death.
(Duration) 1 yrs. mos. ds.Contributory
(SECONDARY)(Signed) E. H. Hutchins M.D.
Sept 13, 1915 (Address) 2217 5th Ave S.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

16-PLACE OF BURIAL

DATE OF BURIAL

17-UNDERTAKER

ADDRESS

SEP 14 1915

ROBERT KRAUTER

Burial Permit Clerk

REGISTRAR

Daniel Taylor, Penna Ave

By Order of Dr. C. Hampton Jones, Health Officer
HEALTH DEPARTMENT - CITY OF BALTIMORE
CERTIFICATE OF DEATH

1. PLACE OF DEATH
CITY OF BALTIMORE (No. 717) Street: 11 WARD (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2. FULL NAME Birnie Thompson
(Residence in Baltimore: No. 717) Street: 16 yrs. mos. ds.)
Known to Dr. Hampton Jones as Burdie Thompson

PERSONAL AND STATISTICAL PARTICULARS
3. SEX male 4. COLOR OR RACE Colored 5. SINGLE, ☒ SINGLE, ☐ MARRIED, ☐ DIVORCED (Write the word) Single

6. DATE OF BIRTH January 28, 1895 (Month) (Day) (Year)

7. AGE 20 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION (a) Trade, profession, or particular kind of work waiter and attendant (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or country) Annapolis, Carroll Co.

10. NAME OF FATHER Louis Thompson

11. BIRTHPLACE OF FATHER (State or country) Carroll Co. Md.

12. MAIDEN NAME OF MOTHER Jane Collins

13. BIRTHPLACE OF MOTHER (State or country) Carroll Co. Md.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jane Thompson (Address) 717 Dmi. Ave.

15. Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 12, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191, that I saw him alive on 191, and that death occurred, on the date stated above, at 4 p.m. The CAUSE OF DEATH* was as follows:

Probably pulmonary Consumption

Contributory (SECONDARY) (Duration) One yrs. mos. ds.

(Signed) Wm. B. McChesney, M.D. 9/13, 1915 (Address) 309 Linden St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER David Easton ADDRESS 916 Rema. Ave.

C88164

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *109 N. Montgomery* ST. 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *109 N. Montgomery* St.; *84* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED, *Married*
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

34 yrs., *3* mos., *13* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lucy Pryor Sister*(Address) *1109 N. Montgomery St.*

SEP 14 1915

Filed *101* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 11, 191*5*.
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *July 10* 191*5*, to *Sept 11* 191*5*, that I saw him alive on *Sept 11* 191*5*, and that death occurred, on the date stated above, at *20* m.

The CAUSE OF DEATH* was as follows:

Enatic Placation
*Infarction*18-CONTRIBUTORY (Duration) *9* yrs., *1* mos., *1* ds.
(Secondary) *Cardiac Disturbance*(Signed) *William H. Brown* M. D.
Sept 17, 191*5*. (Address) *831 E. E. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death *84* yrs., *—* mos., *—* ds. In the State *84* yrs., *—* mos., *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

20-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Int. Auburn St *Sept 17*, 191*5*.

21-UNDERTAKER

ADDRESS

J. L. Brown & Son *108 N. Mont.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No

FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX.

4-COLOR OR RACE.

5-SINGLE, *Ch*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

-DATE OF BIRTH.

-AGE.

-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE.
(State or Country).

10-NAME OF FATHER

11-BIRTHPLACE
OF FATHER
(State or Country)

12-MAIDEN NAME
OF MOTHER

**13-BIRTHPLACE
OF MOTHER
(State or Country).**

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

SEP 14 1915

Filed 1914 10 1914 1914

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

47-1 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on Sept 12 1915

and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Dispersary Peronchus
(Peronchus) Malnutrition

CONTRIBUTORY
(Secondary)

.....2..... (Duration)..... yrs..... mos..... ds.

(Signed) Harold J. Friedman M.D.

1015 (Address) 1815 E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death	YRS. 3	mos. 6	ds.	In the State	YRS.	mos.	ds.
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Where was disease contracted,
if not at place of death? Unknown ✓

Former or usual residence _____

10-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.

CO-UNDERTAKER ADDRESS

George D. Smith 1888-1915

C88166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 C88166
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 1/2 Harris Alley ST.; 1

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Jozefa Moskol

Residence in Baltimore: No. 1001 1/2

St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX. female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

DATE OF BIRTH, July 24, 1915 (Month) (Day) (Year)

AGE, 1 yrs. 20 mos. ds. It LESS than 1 day, hrs. or min.?

OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Jan Moskol

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Anna Slowik

13-BIRTHPLACE OF MOTHER (State or Country), Austria

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Moskol

(Address) 1001 1/2 Harris Alley

SEP 14 1915
Regist. 101. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH September 13, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended decedent from September 12, 1915, to —, 1915, that I saw her alive on September 12, 1915, and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Bacillary Enteritis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leon J. Koska M. D.

Sept. 13, 1915. (Address) 2705 Fair Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

St Stanislaus Bern Sept. 14, 1915.

20-UNDERTAKER ADDRESS

Stephen J. Tralkowski, 1019 Skennore Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88167

CERTIFICATE OF DEATH.

31

C88167

PLACE OF DEATH

CITY OF BALTIMORE: (No. *713 Baker St.* ST. *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Samuel Rice*(Residence in Baltimore: No. *713 Baker* St. *4* yrs., *0* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX, *male* 4-COLOR OR RACE, *colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*DATE OF BIRTH, *Dec* *17*, *1905*
(Month) (Day) (Year)AGE, *9* yrs. *8* mos. *16* ds. If LESS than 1 day,hrs. or....min.?OCCUPATION:
(a) Trade, profession, or particular kind of work. *Schooling*
(b) General nature of industry, business, or establishment in which employed (or employer).....BIRTHPLACE, (State or Country), *City*10-NAME OF FATHER, *William C Rice*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER *Sarah Lett Rice*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Charles Rice*(Address) *713 Baker St.*

SEP 14 1915

Filed *Good* 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept* *13*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 28* 1915, to *Sept 13* 1915, that I saw him alive on *Sept 12* 1915, and that death occurred, on the date stated above, at *14* m.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis
(Duration).....yrs. *5* mos.ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.mos.ds.

(Signed) *J. S. McCard* M. D.
9/13, 1915 (Address) *2005 Hill av*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs.mos.ds. In the State yrs.mos.ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Ch Peters *Sept 14* 1915

20-UNDERTAKER ADDRESS

Samuel Rice *1344 Ocean*

C88168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST. 4

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs., mos. 1 1/2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male.

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

March

17, 1878

7-AGE,

37

5 mos. 27 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer
General

9-BIRTHPLACE, (State or Country),

Md.

10-NAME OF FATHER,

John T. Nolan

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Jethia E. Fisher

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

George Nolan (Brother)

(Address)

Towson, Md.

15-

SEP 14 1915

Filed

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September

13, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Accident struck by electric car at Towson Md.

(Duration)

yrs. mos. 1 1/2 ds.

CONTRIBUTORY (Secondary)

alcoholism

(Duration)

yrs. mos. ds.

(Signed)

Thos. B. Haulcy M. D.

(Coroner.)

Sept. 14, 1915 (Address) 18 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death yrs. mos. 14 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Towson Md.

19-PLACE OF BURIAL OR REMOVAL,

Pleasant Rest Cem.

DATE OF BURIAL,

Sept 14, 1915

20-UNDERTAKER

Towson Md.
John Burns Sons

ADDRESS

Towson

C88169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159 C88169

PLACE OF DEATH
CITY OF BALTIMORE (No. *Franklin Sq. Hopt.* ST.: *24*)
FULL NAME *Henry Martin*
Residence in Baltimore: No. *310 E. Randall*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

St.: yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
4-COLOR OR RACE, *white*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widowed*
(Write the word.)
6-DATE OF BIRTH, *April 30th 1853*
(Month) (Day) (Year)
7-AGE, *62* yrs. *4* mos. *15* ds.
If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *R.R. Conductor*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Front Royal, Va.*

PARENTS.
10-NAME OF FATHER, *Alfred Martin*
11-BIRTHPLACE OF FATHER (State or Country), *Va*
12-MAIDEN NAME OF MOTHER, *Evelyn Garrett*
13-BIRTHPLACE OF MOTHER (State or Country), *Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Martin*
(Address) *310 E. Randall*

15-SEP 14 1915

Filed

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, *Sept. 13th 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*
(Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound
Suicide
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Sam'l H. Hinkley* M. D.
Sept 14 1915 (Coroner)
(Address) *2302 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. *1* In the State *4* yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?...

310 E. Randall St.
Former or usual residence *310 E. Randall St.*

19-PLACE OF BURIAL OR REMOVAL,

Mt. Olivet Cem.

DATE OF BURIAL,

Sept. 14, 1915

20-UNDERTAKER

J. Frew McCall

ADDRESS

37 E. Fort.

C88170

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 16 WARD)

FULL NAME

(Residence in Baltimore: No.

St.: yrs. 11 mos. 12 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
or --- min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)9-BIRTHPLACE
(State or country)10-NAME OF
FATHER11-BIRTHPLACE
OF FATHER
(State or country)12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) E. Heller M.D.

Sept. 13, 1915 (Address) 2000 Hollins St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

SEP 14 1915

Filed

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 Mulliken ST. 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1505 Mulliken St.; 3 yrs., 2 mos., 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX. <u>Male</u>	4-COLOR OR RACE, <u>Black</u>	5-SINGLE, MARRIED, <u>Single</u> WIDOWED, OR DIVORCED (Write the word.)
---------------------	----------------------------------	---

DATE OF BIRTH, <u>May 23rd</u> , <u>1915</u> (Month) (Day) (Year)
--

AGE, <u>3</u> yrs., <u>21</u> mos., <u>21</u> ds.	IF LESS than 1 day, ...hrs. or...min.?
--	---

OCCUPATION:
(a) Trade, profession, or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer)...

BIRTHPLACE.
(State or Country), Ind. City10-NAME OF FATHER, Refus Smith11-BIRTHPLACE OF FATHER
(State or Country), Va.12-MAIDEN NAME OF MOTHER Geneva Young13-BIRTHPLACE OF MOTHER
(State or Country), Ind.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary C. Young(Address) 1505 Mulliken

SEP 14 1915

Filed Rock 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 13th 1915, to Sept 13th 1915, that I saw him alive on Sept 13th 1915, and that death occurred, on the date stated above, at 10.20 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(Duration) 3 yrs., 2 mos., 2 ds.CONTRIBUTORY (Secondary) Same(Duration) 3 yrs., 2 mos., 2 ds.(Signed) Prof. L. W. Young M. D.9.13.1915 (Address) 30 S. B. Way

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs., 2 mos., 2 ds. In the State Ind. yrs., 2 mos., 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Suburban Cem.DATE OF BURIAL, Sept 13th 191520-UNDERTAKER Harry A. VoderADDRESS 1725 Orleans St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 13 yrs. 13 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

widower

6-DATE OF BIRTH,

Dec.

25

1856

(Month)

(Day)

(Year)

7-AGE.

58

8

18

ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Driver

(b) General nature of industry, business, or establishment in which employed (or employer).

unknown

9-BIRTHPLACE,

(State or Country),

Balto, Md.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Robinson

13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Walter M. Kelly

(Address)

2658 Florence St.

15-

SEP 14 1915

Filed

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept.

13

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an... inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said...

inquiry

and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess

(Duration)

1

yr.

mos.

ds.

CONTRIBUTORY (Secondary)

Pulmonary Hemorrhage

(Duration)

1

yr.

mos.

ds.

(Signed)

W. M. Savage

M. D.

(Coroner)

Sept. 13, 1915

(Address) 1724 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death... yrs.... mos.... ds. State... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenwood Park

Sept. 15, 1915

20-UNDERTAKER

ADDRESS

Wm Cook

5028 North

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88173

CERTIFICATE OF DEATH

109

C88173

PLACE OF DEATH

(Clara Mana Roemhildt)

REGISTERED NO. C

CITY OF BALTIMORE (No.

Hebrew Hospital

ST.

8

WARD)

2-FULL NAME

Clara Mana Roemhildt

(If death occurred in a hospital or institution, give its NAME instead of street and number and list out No. 18.)

(Residence in Baltimore: No.

1731 N. Patterson Pl. ave.

ST.

35

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

white

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)widowed
Divorced

6-DATE OF BIRTH

Aug.

17th, 1889

(Month)

(Day)

(Year)

7-AGE

46

yrs.

mos.

25

ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

Germany

10-NAME OF FATHER

Carl Caccia

PARENTS

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albertina Baergerich

(Address)

1729 N. Montford ave

15

SEP 14 1915

Filed

Gross

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept

11

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 30

1915

to

Sept 11

1915

that I saw him alive on

and that death occurred, on the date stated above, at 11.10 P.M.

The CAUSE OF DEATH* was as follows:

intestinal obstruction
due to enterolith

(Duration)

yrs.

mos.

3

ds.

Contributory
(SECONDARY)

Uremia

(Duration)

yrs.

mos.

10

ds.

(Signed)

M. B. Levine

M. D.

Sept 12th, 1915

(Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

Where was disease contracted?

If not at place of death?

Former or

usual residence

yrs. mos. 13 ds. In the 35 yrs. mos. ds.

1731 N. Patterson Pl. ave

1731 N. Patterson Pl. ave

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cemetery

Sept 15, 1915

20-UNDERTAKER

ADDRESS

George Schelling Sons

1126 E. Monument St

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 15 WARD)

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6-DATE OF BIRTH *Sept. 26, 1887*
(Month) (Day) (Year)

7-AGE *28 yrs. 7 mos. 19 ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work *Stenographer*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Balto City Md.

10-NAME OF FATHER

Maurice Hanrahan

PARENTS

11-BIRTHPLACE OF FATHER (State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Johanna Downes

13-BIRTHPLACE OF MOTHER (State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maurice J. Hanrahan

(Address)

1345 N. Gilman St.

15 SEP 14 1915

Filed

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept. 12, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept. 1, 1915* to *Sept. 12, 1915*.

that I saw her alive on *Sept. 12, 1915*.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast
(Clinical Diagnosis)

Contributory (SECONDARY)

Coronary Dilatation
(Duration) yrs. 6 mos. ds.

(Signed) *Robert C. Blake* M. D.

Sept. 13, 1915 (Address) *1014 W. Fa. Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

New Cathedral

DATE OF BURIAL

Sept. 15, 1915

20-UNDERTAKER

Robt. T. Turner

ADDRESS

Broadway & Chas.

C88175

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 E. Oliver

ST. 9

WARD

2-FULL NAME

Mary Lillie Houston

(Residence in Baltimore: No. 1428 E. Oliver st.

St. Life

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

Oct

21

1864

(Month)

(Day)

(Year)

7-AGE

50

yrs. 11

mos. 21

ds.

or min.?

If LESS than

1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

Baltimore

10-NAME OF FATHER

W. Mitchell

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

Matha A. C. Riley

13-BIRTHPLACE OF MOTHER
(State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Annie Mitchell

(Address)

1428 E. Oliver st.

15-SEP 14 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept

12

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March, 1915, to Sept 11, 1915,

that I saw him alive on Sept 11, 1915,

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

operation
Recurrent Carcinoma of Breast

(Duration)

1

yrs.

11

mos.

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

J. Walter Thomas

M. D.

Sept 12, 1915

[Address]

1225 D. Caroline

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

In the

ds.

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Greenmount Cemetery

DATE OF BURIAL

Sept. 14

1915

20-UNDERTAKER

Lester F. Fussellbaugh

ADDRESS

2620 St Paul st.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. *1811 Orleans* ST. *6* WARD)2-FULL NAME *Mary T. Funk*(Residence in Baltimore: No. *1811 Orleans St*)St.; *—* yrs. *—* mos. *—* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *Married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

April 10th 1891
(Month) (Day) (Year)

7-AGE

24 yrs. *5* mos. *3* ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*House wife*9-BIRTHPLACE
(State or country)*Md*

10-NAME OF FATHER

*James A. Frank*11-BIRTHPLACE OF FATHER
(State or country)*Md*

12-MAIDEN NAME OF MOTHER

*Cora E. Barber*13-BIRTHPLACE OF MOTHER
(State or country)*Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Edward L. Funk*
(Address) *1811 Orleans St*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September 13, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Oct —*, 191*4*, to *Sept 13*, 191*5*that I saw her alive on *Sept 12*, 191*5*, and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus & appendages. (Operative Pathology diagnosis)
(Duration) yrs. *11* mos. *—* ds.Contributory
(SECONDARY)*Carcinoma of uterus & appendages*
(Duration) yrs. *—* mos. *—* ds.
(Signed) *Charles E. Helwig* M. D.
Sept 13, 191*5* [Address] *1419 E Edge St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. *—* mos. *—* ds. In the State yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

David Ridge Cemetery

DATE OF BURIAL

Sept 16, 1915

20-UNDERTAKER

Christian Miller

ADDRESS

233 E. [illegible]

18-SEP 14 1915

FHM *95* 181

REGISTRAR

C88177

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 C88177
REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 2724 St. Charles

ST. 12 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Marian S. Beazley

(Residence in Baltimore: No. 2103 St. Charles

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

2

?

1869

(Month)

(Day)

(Year)

7 AGE

46

yrs.

mos.

ds.

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Florida

10 NAME OF FATHER

Wm. Scott

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Katherine Bird

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. S. Chamberlain

(Address)

Plex Va.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept

13, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 8th, 1915, to, Sept 13, 1915.

that I saw her alive on Sept 13, 1915.

and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Heart Disease

Contributory
(SECONDARY)Acute dilatation
of the heart. 3
(Duration) yrs. mos. ds.

(Signed)

W. H. Pearson M. D.

Sept 13, 1915 (Address) 2103 St. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

2103 St. Charles Street

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Lauden Park

DATE OF BURIAL

Sept. 14, 1915

20 UNDERTAKER

E. M. Mitchell & Co.

ADDRESS

120 W. Fayette

REGISTRAR

SEP 14 1915

Filed

Pocah

C88178

HEALTH DEPARTMENT--CITY OF BALTIMORE

28 C88178

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 2537 Ashton

ST. 20

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Margaret M Leonard

(Residence in Baltimore: No. 2537 Ashton

St. 25 yrs. 10 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6-DATE OF BIRTH

Oct 22, 1889
(Month) (Day) (Year)

7-AGE

25 yrs. 10 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work Shift factory work
(b) General nature of industry, business, or establishment in which employed (or employer) Operator

9-BIRTHPLACE (State or country)

Baltimore

10-NAME OF FATHER

Chas. Leonard

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Annie B. Smith

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Leonard

(Address)

2537 Ashton St

15

SEP 14 1915

Filed

191

HARRY O. ANDREWS
Berial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 11, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 23, 1915, to, Sept 11, 1915.

that I saw him alive on Sept 11, 1915.

and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Rapid Tuberculosis of Lungs
& Infection

(Duration) yrs. 1 mos. 20 ds.

Contributory (SECONDARY)

Infection

(Duration) yrs. 16 mos. 16 ds.

(Signed)

Joseph A. Gidycz, M.D.
Sept 14, 1915 (Address) 1516 Madison av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

New Cathedral Cem

DATE OF BURIAL

Sept 15, 1915

20-UNDERTAKER

John P. Wells 1200 N. Lombard St

ADDRESS

C88179

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88179

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. *Phipps Psych. Clinic, J.H.H. St.* 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and "In out No. 18.")

2-FULL NAME

Rose Hepburn(Residence in Baltimore: No. *1224 Riverside Ave*St.; *19* yrs. *11* mos. *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*Single*

6-DATE OF BIRTH

Sept. 1

(Month)

(Day)

1896

(Year)

7-AGE

19

yrs.

mos.

14

ds.

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)*CLERK in
laundry*

9-BIRTHPLACE

(State or country)

*Balt. Md.*10-NAME OF
FATHER11-BIRTHPLACE
OF FATHER
(State or country)12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or country)

PARENTS

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

SEP 14 1915

191

HARRY O. ANDREWS,
Burial Permit Officer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept.

(Month)

12

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from
Sept. 2nd, 1915, to, *Sept. 12*, 1915,
that I saw *h.e.r.* alive on *Sept. 12*, 1915,
and that death occurred, on the date stated above, at *8.25 p.m.*
The CAUSE OF DEATH* was as follows:*tuberculosis (acute military)*

(Duration)

yrs.

34

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

P.W. Hall

M. D.

Sept. 12, 1915

[Address]

*Phipps Psych. Clinic, J.H.H.** State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS]

At place

of death

yrs.

mos.

In the

State

19

yrs.

mos.

11

ds.

Where was disease contracted,
if not at place of death?*Probably at home*

Former or

usual residence

1224 Riverside Ave, Balt. Md.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH
 1-PLACE OF DEATH *259 N Schroeder St*
 CITY OF BALTIMORE: WARD *18*
 2-FULL NAME *N. Andrew T Brooke*
 (Residence in Baltimore: No. *259 N Schroeder St*; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS
 3-SEX *Male* 4-COLOR OR RACE *Coel* 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Single*
 6-DATE OF BIRTH *Unknown* (Month) (Day) (Year)
 7-AGE *51* yrs. mos. ds. or 1 day, hrs. min.?
 8-OCCUPATION (a) Trade, profession or particular kind of work *Barber* (b) General nature of industry, business, or establishment in which employed (or employer) *Ind.*
 9-BIRTHPLACE (State or country) *Ind.*
 10-NAME OF FATHER *G. H. T Brooke*
 11-BIRTHPLACE OF FATHER (State or country) *Ind.*
 12-MAIDEN NAME OF MOTHER *Mamie Cornish*
 13-BIRTHPLACE OF MOTHER (State or country) *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Mamie T Brooke*
 (Address) *1507 N Dorsey*

15-SEP 14 1915 HARRY O ANDREWS, Registrar

MEDICAL CERTIFICATE OF DEATH
 16-DATE OF DEATH *Sept 11, 1915* (Month) (Day) (Year)
 17-I HEREBY CERTIFY, That I attended deceased from *Sept 1, 1915* to *Sept 11, 1915*, that I saw him alive on *Sept 11, 1915* and that death occurred, on the date stated above, at *5 P.M.*
 The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
 (Duration) *1* yrs. mos. ds.
 Contributory (SECONDARY) *Thrombosis of a* (Duration) *3* yrs. mos. ds.
 (Signed) *J. D. Morwood* M. D.
 (Address) *939 N. Troy Ave*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
 At place of death, yrs. mos. ds. In the State, yrs. mos. ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *St. Stephen's Cemetery*
 20-UNDERTAKER *Charles B Jones*
 DATE OF BURIAL *Sept 15, 1915*
 ADDRESS *1118 N. S. Ave*

C88181

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88181

CERTIFICATE OF DEATH.

103
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 S. Duncan ST.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick H. Winkleriska(Residence in Baltimore: No. 311 S. Duncan St. Life yrs., 1 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 27th, 1911
(Month) (Day) (Year)

7-AGE, 3 yrs., 11 mos., 16 da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto City M.d.

10-NAME OF FATHER, John H. Winkleriska

11-BIRTHPLACE OF FATHER (State or Country), Balto City M.d.

12-MAIDEN NAME OF MOTHER Estella Paity

13-BIRTHPLACE OF MOTHER (State or Country), Balto City M.d.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Winkleriska(Address) 311 S. Duncan St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1915, to Sept 13 1915, that I saw him alive on Sept 13 1915, and that death occurred, on the date stated above, at 4:50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion - Convulsions
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY... Cardiac Exhaustion
(Secondary)

(Signed) A. L. Cunningham M. D.
Sept 14, 1915 (Address) 2013 1/2 Bank St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount Carmel Sept 15, 1915

20-UNDERTAKER

ADDRESS

J. Sander & Sons 1714 Bldg

SEP 14 1915

HARRY O. ANDREWS

Regist.

Registrar.

C88182

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

81

C88182

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

ST.

WARD)

FULL NAME

(Residence in Baltimore: No.

St.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)9-BIRTHPLACE
(State or country)10-NAME OF
FATHER11-BIRTHPLACE
OF FATHER
(State or country)12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I attended deceased from

June 26th, 191⁵, to Sept 12th, 191⁵.that I saw her alive on Sept 12th, 191⁵.and that death occurred, on the date stated above, at 10⁰⁰ m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.

Contributory
(SECONDARY)

(Signed)

Sept 14, 191⁵

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

SEP 15 1915

SEP 15 1915

ROBERT KRAUTH,

Bureau Permit Clerk

REGISTRAR

Harry B. Branning

9-15-1915

517 N. Schroeder St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *1533 Druid Hill Ave* ST. *14* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1533 Druid Hill Ave* St. *13* yrs., mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX, *Female* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, *Single* WIDOWED, OR DIVORCED (Write the word.)DATE OF BIRTH, *unknown*, 1 (Month) (Day) (Year)AGE, *22* yrs. mos. da. If LESS than 1 day, ...hrs. or ...min.OCCUPATION: (a) Trade, profession, or particular kind of work, *none* (b) General nature of industry, business, or establishment in which employed (or employer)BIRTHPLACE, (State or Country), *Virginia*10-NAME OF FATHER, *Chas. Jordan*11-BIRTHPLACE OF FATHER (State or Country), *Virginia*12-MAIDEN NAME OF MOTHER, *Sarah Boykin*13-BIRTHPLACE OF MOTHER (State or Country), *Virginia*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sarah Jordan*(Address) *1533 Druid Hill Ave*

SEP 15 1915

ROBERT KRAUTH

Filed... 191... REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 14*, 191*5* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 24* 191*5*, to *Sept 13* 191*5*, that I saw him alive on *Sept 13* 191*5*, and that death occurred, on the date stated above, at *1/2* m.

The CAUSE OF DEATH* was as follows:

*Acute & chronic nephritis*CONTRIBUTORY (Secondary) *Exhaustion*(Signed) *Felix B. Pye* M. D. (Address) *1418 S. 10th*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mc Auburn Cemetery

DATE OF BURIAL,

Sept. 16th, 1915.

20-UNDERTAKER

Felix B. Pye

ADDRESS

102 E. Mulberry St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.; *14* WARD)FULL NAME *John Harlow*(Residence in Baltimore: No. *1925 Druid Hill Ave* St.; *Life* yrs. *4* mos. *27* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX. *male* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)

2-DATE OF BIRTH, *May 16*, 1899 (Month) (Day) (Year)

3-AGE, *16* yrs. *4* mos. *27* ds. If LESS than 1 day, ... hrs. or ... min.?

OCCUPATION:
(a) Trade, profession, or particular kind of work. *School boy*
(b) General nature of industry, business, or establishment in which employed (or employer).

4-BIRTHPLACE, (State or Country), *Maryland, Balto*

10-NAME OF FATHER, *John Harlow*

11-BIRTHPLACE OF FATHER (State or Country), *md*

12-MAIDEN NAME OF MOTHER *Marie Brunell*

13-BIRTHPLACE OF MOTHER (State or Country), *Da.*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. J. Smith*(Address) *Johns Hopkins Hosp*

SEP 15 1915

1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 13, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 24* 1915, to *Sept 13* 1915, that I saw him alive on *Sept 13* 1915, and that death occurred, on the date stated above, at *5:25* a.m.

The CAUSE OF DEATH* was as follows:

Sarcina at Lung in
Maternal Infection.

(Duration) *4* yrs. *4* mos. *24* ds.

CONTRIBUTORY (Secondary)

Operation (Duration) *18* yrs. *18* mos. *18* ds.

(Signed) *George B. D. ... M. D.*

Sept 13, 1915. (Address) *Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *2* mos. *21* ds. In the State *✓* yrs. *✓* mos. *✓* ds.

Where was disease contracted, if not at place of death? *✓*

Former or usual residence *1925 Druid Hill Ave*

19-PLACE OF BURIAL OR REMOVAL,

St. Auburn

DATE OF BURIAL,

Sept 15 1915

20-UNDERTAKER

*John H. Toadun*ADDRESS *143**W. Hill St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Provident Hospital* ST. *11* WARD) (If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME *Wesley Cox*

3-Residence in Baltimore: No. *933 Linden Ave* St. *20* yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX. *Male* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married* (Write the word.)

6-DATE OF BIRTH, *Unknown*, *1887* (Month) (Day) (Year)

7-AGE, *28* yrs. — mos. — ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Labourer*
(b) General nature of industry, business, or establishment in which employed (or employer). *General*

9-BIRTHPLACE, (State or Country), *Va.*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mellie Cox*
(Address) *933 Linden Ave*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 12*, 1915.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Sept 4* 1915, to *Sept 12* 1915, that I saw him alive on *Sept 12* 1915, and that death occurred, on the date stated above, at *6:42 am*.

The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar)

(Duration) — yrs. — mos. — ds. *10*
CONTRIBUTORY (Secondary) *Cardiac dilatation*
(Duration) — yrs. — mos. — ds. *3*

(Signed) *R. P. Krauth* M. D.
Sept 13, 1915. (Address) *2249 W. 3rd St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. *10* In the State *W* yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence *933 Linden Ave*

19-PLACE OF BURIAL OR REMOVAL, *Int. Auburn* DATE OF BURIAL, *Sept 15, 1915*

20-UNDERTAKER *John H. Toadwire* ADDRESS *142 W. Hill St*

SEP 15 1915

ROBERT KRAUTH
Burial Permit Officer
Registrar.

HEALTH DEPARTMENT--CITY OF BALTIMORE
CERTIFICATE OF DEATH

C88187

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Pennsylvania Ave. 14

2-FULL NAME James A. Webb

Residence in Baltimore: No. 1605 Pennsylvania Ave. St. 14th

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and Room No. 12.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED

Married

6-DATE OF BIRTH

March 13th 1850

7-AGE

65 yrs 6 mos 1 day

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Produce Dealer

9-BIRTHPLACE
(State or country)

Baltimore

10-NAME OF FATHER

Jacob W Webb

11-BIRTHPLACE OF FATHER
(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Elizabeth A Ford

13-BIRTHPLACE OF MOTHER
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth A Webb

(Address) 1605 Pennsylvania Ave

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

Sept. 14th 1915

17- I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1915, to, Sept. 14, 1915, that I saw him alive on Sept. 14, 1915, and that death occurred, on the date stated above, at 3:20 P.M. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory (SECONDARY) Cerebral apoplexy

(Signed) C. Urban Smith
Sept 15, 1915 (Address) 817 Park Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

Sept 17, 1915

ADDRESS

20-UNDERTAKER

J. F. Walker

723 Wharf St

SEP 15 1915

ROBERT KRAUTER, REGISTRAR

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88189

CERTIFICATE OF DEATH

108

C88189

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *Hehren Hosp* ST. *3* WARD)2-FULL NAME *Hannah Berlin*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1404 E - Lombard St.* *27* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word)

6-DATE OF BIRTH *Unknown*, 18*89*
(Month) (Day) (Year)

7-AGE *46* yrs. *—* mos. *—* ds. or *—* mo. *—* hrs. *—* min. *—* sec.
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)*Russia*

10-NAME OF FATHER *David Masenoff*

11-BIRTHPLACE OF FATHER (State or country) *Russia*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or country) *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

SEP 15 1915

ROBERT

KRAUTER

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 10, 1915, to *Sept 15, 1915*,
that I saw her alive on *Sept 15, 1915*,
and that death occurred, on the date stated above, at *12:30* a.m.

The CAUSE OF DEATH* was as follows:

*Gangrenous
appendix*

Contributory
(SECONDARY)

(Duration) *3* yrs. *—* mos. *—* ds.

(Signed) *M. B. Lewis* M. D.

115, 191*5* (Address) *Hehren Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *5* yrs. *—* mos. *—* ds. In the *21* yrs. *—* mos. *—* ds. State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, *1404 E Lombard St.*
If not at place of death?

Former or usual residence *1404 E Lombard St.*

19-PLACE OF BURIAL OR REMOVAL

Hehren Roseclade

DATE OF BURIAL

9/15, 1915

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Balt

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hargis* ST. *6* WARD)2-FULL NAME *Anna Belick Harnal*(Residence in Baltimore: No. *217 N. High* St.; *15* yrs., *15* mos., *15* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX. *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

DATE OF BIRTH.

Unknown, *1862*
(Month) (Day) (Year)

AGE,

53 yrs., *—* mos., *—* ds.If LESS than 1 day,
...hrs. or...min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*BIRTHPLACE,
(State or Country)10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER
(State or Country), *Russia*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER
(State or Country), *Russia*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Lewis*(Address) *1419 E. Baltimore*

SEP 15 1915

ROBERT KRAUTER,
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 15, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept. 11, 1915* to *Sept. 15, 1915*, that I saw her alive on *Sept. 15, 1915*, and that death occurred, on the date stated above, at *1:00 am*.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) *About 18 mos.*CONTRIBUTORY
(Secondary) *General debility*(Duration) *Don't know*(Signed) *Frank M. Mearns, M. D.**Sept. 15, 1915* (Address) *Mary Hargis*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *5* yrs., *15* mos., *15* ds. In the *15* yrs., *15* mos., *15* ds.Where was disease contracted, if not at place of death? *Don't know*Former or usual residence *217 N. High*

19-PLACE OF BURIAL OR REMOVAL,

Acheson Wash Rd

DATE OF BURIAL,

9/15, 1915

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Baltimore


P. 6120

LEVIN & SILVERBERG
ATTORNEYS AND COUNSELORS AT LAW
518-19 LAW BUILDING
BALTIMORE, MD.

STATE OF MARYLAND, CITY OF BALTIMORE, to wit:

I hereby certify that on this twenty-second day of September, in the year One Thousand Nine Hundred and Fifteen before me, the subscriber, a Notary Public of the State of Maryland, in and for the City of Baltimore aforesaid, personally appeared Abraham Bellock, son of the late Hannah Bellock, and made oath in due form of law that his mother had departed this life on the fifteenth day of September, in the year One Thousand Nine Hundred and Fifteen, while undergoing treatment and being a patient at the Mercy Hospital, situated in the City and State aforesaid, and the deponent, the said Abraham Bellock, further affirms that his mother's name as it appeared on the death certificate furnished by the authorities of the aforesaid hospital had been erroneously set forth as Annie Belick and that Hannah Bellock and Annie Bellock are one and the same person.

As witness my hand and Notarial Seal.


Simon Silverberg
.....
Notary Public.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88191

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No.

1819 N. Baltimore

ST.;

WARD)

REGISTERED NO. C

FULL NAME

Margaret E. Wilcox

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1819 N. Baltimore

St.; 70 yrs., 8 mos., 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Widowed

DATE OF BIRTH,

Dec.

29

1844

(Month)

(Day)

(Year)

AGE,

70 yrs., 8 mos., 15 ds.

If LESS than 1 day,
...hrs. or...min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

BIRTHPLACE,
(State or Country),

Baltimore City

10-NAME OF FATHER,

Charles H. Semitz

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Anna Margaret Kessler

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Florence Lobb

(Address)

1819 N. Balti. St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

13

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 10

1915

to Sept 13

1915

that I saw her alive on

Sept 13

1915

and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Heart Prostration

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

E. B. Britton

M. D.

Sept 13, 1915 (Address) 1711 E. Balti. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,
if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

Sept 15, 1915

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1603 Wood
Baltimore St

SEP 15 1915

Filed.....1915

ROBERT KRAUTER
Burial Permit Clerk
Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

512 Archer St

ST.; 21 WARD)

REGISTERED NO. C

2. FULL NAME

Beatrice Burke

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

512 Archer St

St.; yrs. 10 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX.

female

4. COLOR OR RACE,

white.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6. DATE OF BIRTH

Sept 1

(Month)

(Day)

1914 (Year)

7. AGE,

10 yrs. 13 mos.

13 ds.

If LESS than 1 day,

hrs. or min.

8. OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9. BIRTHPLACE, (State or Country),

Baltimore

10. NAME OF FATHER

James M. Burke

11. BIRTHPLACE OF FATHER (State or Country)

Boston Mass

12. MAIDEN NAME OF MOTHER

Elizabeth Palmer

13. BIRTHPLACE OF MOTHER (State or Country)

Baltimore

4. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Elizabeth Burke

(Address)

512 Archer St

SEP 15 1915

ROBERT KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 14th

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1 1915, to Sept 14 1915,

that I saw her alive on Sept 14 1915,

and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. 10 mos. 13 ds.

CONTRIBUTORY (Secondary)

improper food

(Duration) yrs. 7 mos. 10 ds.

(Signed)

Stephen D. Drain M. D.

Sept 14, 1915 (Address) 1227 Columbia St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

New Cathedral Ave

DATE OF BURIAL

Sept 14, 1915

20. UNDERTAKER

John Hawson

ADDRESS

907 Hollins St

C88193 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 C88193
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

708 W Lexington St 4

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Henry Spenner

(Residence in Baltimore: No.

708 W. Lexington St

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male
4-COLOR OR RACE white
5-SINGLE, MARRIED, WIDOWED OR DIVORCED married.
(Write the word)6-DATE OF BIRTH August 15, 1859
(Month) (Day) (Year)

7-AGE 56 yrs. 0 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Janitor
Knickknack Bldg9-BIRTHPLACE
(State or country)

Baltimore, Md.

10-NAME OF FATHER

John Spenner

11-BIRTHPLACE OF FATHER
(State or country)

Germany.

12-MAIDEN NAME OF MOTHER

Margaret Herman

13-BIRTHPLACE OF MOTHER
(State or country)

Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frederick Spenner

(Address)

708 W Lexington St.

15.

SEP 15 1915

ROBERT KRAUTH,

Bureau Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept 13, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY. That I attended deceased from Sept 10, 1915, to Sept 13, 1915, that I saw him alive on Sept 13, 1915, and that death occurred on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

endocarditis and dilatation of heart.

Contributory (Duration) no yrs. no mos. 4 ds.
(SECONDARY) inflammatory rheumatism(Signed) Chester (Kiland) M. D.
Sept 14, 1915. (Address) 2532 Edmond Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Louden Park

DATE OF BURIAL

Sep 15, 1915

20-UNDERTAKER

John Horvath & Son

ADDRESS

901 Hollman

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.

St. Vincent's Inf. Asy.

ST.

WARD)

REGISTERED NO. C

2-FULL NAME

Teresa Martin

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

St. Vincent's Infant Asylum

St.;

yrs., *10* mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)*Single*

-DATE OF BIRTH,

October 28, 1914
(Month) (Day) (Year)

-AGE,

10 mos. 14 ds.

If LESS than 1 day,

...hrs. or...min.?

-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

5-SEP 15 1915

Filed *980* 191.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 12, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Sept. 1st 1915, to Sept. 12th 1915,*that I saw her alive on *Sept. 11th 1915,*and that death occurred, on the date stated above, at *6:30 a.m.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) ... yrs. ... mos. ... *5* ds.CONTRIBUTORY
(Secondary)(Duration) ... yrs. ... *2* mos. ... ds.(Signed) *John S. Farley* M. D.*Sept. 13, 1915* (Address) *1223 W. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *10* mos. ... ds. In the State yrs. *10* mos. *14* ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral cem *Sept. 15, 1915*

20-UNDERTAKER

ADDRESS

Martin F. Fehrs, 606 Lafayette Ave

88195

HEALTH DEPARTMENT—CITY OF BALTIMORE

151/2
88195

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1412 N. Parrish street, ST. 13 WARD)

FULL NAME William Hanson,

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Residence in Baltimore: No. 1422 N. Parrish street, St.: yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, single, (Write the word.)

6-DATE OF BIRTH, June 14th, 1915. (Month) (Day) (Year)

7-AGE, 0 yrs., 3 mos., 0 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS. 10-NAME OF FATHER, William Hanson, 11-BIRTHPLACE OF FATHER (State or Country), Virginia, 12-MAIDEN NAME OF MOTHER, Lucy Coates, 13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Lucy Coates, mother, (Address) 1422 N. Parrish Street.

15- SEP 15 1915

Filed, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 14, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry and that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Inanition, due to artificial feeding, (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) J. Frederick Hempel, M. D. (Coroner.) Sept. 15, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

20-UNDERTAKER, ADDRESS

88196

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2918 Presstman ST. 15 WARD)2-FULL NAME George M. Lohrmann

(If death occurred in a hospital or institution, give its NAME instead of street and number and add No. 18.)

(Residence in Baltimore: No. 2918 Presstman St.; 50 yrs. 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Sept. 26 1850
(Month) (Day) (Year)

7-AGE

64 yrs. 11 mos. 17 ds. or min.?
If LESS than 1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Baker9-BIRTHPLACE
(State or country)Germany

10-NAME OF FATHER

Michael Lohrmann11-BIRTHPLACE OF FATHER
(State or country)Germany

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or country)Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louise Lohrmann

(Address)

2918 Presstman

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

Sept. 13 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 19, 1915, to Sept. 13, 1915, that I saw him alive on Sept. 12, 1915, and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Cirrhosis of LiverContributory
(SECONDARY)(Duration) yrs. 23 mos. 24 ds.Inanition(Duration) yrs. 7 mos. 4 ds.(Signed) Dr. Gombel M. D.Sept. 15, 1915 [Address] 1704 Madison Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. 0 mos. 0 ds. State yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Bur.

DATE OF BURIAL

Sept. 15, 1915

20-UNDERTAKER

E. Schloman

ADDRESS

1039 Hanover St.

18 SEP 15 1915

Filed

191

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, No.

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

Oct 1st, 1856

(Month)

(Day)

(Year)

7-AGE,

58

yrs.

11

mos.

12

ds.

If LESS than 1 day,

...hrs. or...min.?

OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

Housework

8-BIRTHPLACE,

(State or Country).

Balto Md.

10-NAME OF FATHER,

John Brent

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

John O. Chey

(Address)...

2047 Fleet St.

SEP 15 1915

ROBERT

KRAUTER,

Birtal Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 13th, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 29, 1915, to Sept 13, 1915,

that I saw her alive on Sept 12, 1915,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. A. Gearty M. D.

Sept 14, 1915. (Address) 3244 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn

20-UNDERTAKER

John A. Moran & Ann

DATE OF BURIAL,

Sept 13th, 1915

ADDRESS

Oak Lawn

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1516 Druidhill avenue, ST. 14 WARD)

FULL NAME Edward Williams,

(Residence in Baltimore: No. 1516 Druidhill avenue,

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE. Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed,

6-DATE OF BIRTH, Unknown, / (Month) (Day) (Year)

7-AGE, 59 ? yrs. ? mos. ? ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Day laborer, (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland,

PARENTS.	10-NAME OF FATHER, Thomas Williams,
	11-BIRTHPLACE OF FATHER (State or Country), Unknown,
	12-MAIDEN NAME OF MOTHER Rachel White,
	13-BIRTHPLACE OF MOTHER (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank R. Williams, brother,

(Address).....755 George street,.....

15-ROBERT KRAUTER, Registrar.

SEP 15 1915

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 12th 1915. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis,

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Frederick Hempel, M. D. (Coroner.)

Sept. 13, 1915. (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Sept. 15 1915

20-UNDERTAKER

ADDRESS 517

Registrar.

George H. Holland

Robert St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 W. Lexington ST. 4)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Eva Rosenberg(Residence in Baltimore: No. 701 W. LexingtonSt.; 60 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH

Nov

(Month)

21

(Day)

1954

(Year)

7-AGE

69

yrs.

mos.

17

ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

HousewifeGermany

10-NAME OF FATHER

Elmer Hoff

11-BIRTHPLACE OF FATHER

Germany

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER

Germany

(State or Country),

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Harris(Address) 701 W. Lexington St.

SEP 15 1915

ROBERT

KRAUTER,

Med. 191. ...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

September 14, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1915, to Sept 14 1915that I saw her alive on Sept 14 1915and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Thrombosis of right femoralvein(Duration) 3 yrs., 3 mos., 1 ds.CONTRIBUTORY Myocardial Infarction(Secondary) (Duration) 1 yrs., 1 mos., 1 ds.(Signed) Dr. F. J. Zuercher M. D.Sept 11, 1915 (Address) 21 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,

state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or

HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-

FERRENTS, OR RECENT RESIDENTS).

At place of death 7 yrs., 3 mos., 1 ds. In the 7 yrs., 3 mos., 1 ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Chel Shalom

DATE OF BURIAL

Sept 14 1915

20-UNDERTAKER

J. Ahrens & Co

ADDRESS

1611 Madison Ave

88200

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88200

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hosp

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Robert C Wells

Residence in Baltimore: No.

408 E. 22nd St

St.:

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX.

male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

-DATE OF BIRTH,

May

22

1869

(Month)

(Day)

(Year)

-AGE,

46

yrs.

3

mos.

20

ds.

If LESS than 1 day,

....hrs. or....min.?

-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Printer

(b) General nature of industry, business, or establishment in which employed (or employer).

-BIRTHPLACE,
(State or Country),

Md. Balt

10-NAME OF FATHER,

Robert H. Wells

11-BIRTHPLACE OF FATHER
(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Mary Binnie

13-BIRTHPLACE OF MOTHER
(State or Country),

Scotland

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

A. J. Smith

(Address)

Johns Hopkins Hospital

SEP 15 1915

ROBERT C. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September

13

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

September 8, 1915, to Sept 13, 1915,

that I saw him alive on September 13, 1915,

and that death occurred, on the date stated above, at 12:00 p.m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis, Myocarditis
(chronic)

(Duration)....yrs....mos....ds.

CONTRIBUTORY
(Secondary)

Broncho Pneumonia

(Duration)....yrs....mos....ds.

(Signed).....M. D.

Sept 13, 1915. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

408 E. 22nd St

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Wood Lawn Cem

Sept. 16, 1915

20-UNDERTAKER

ADDRESS

Wm. B. Black 927 N. Boling

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

SEP 15 1915

ROBERT KRAUTER
Burial Permit Officer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(Clinical Diagnosis)

Contributory (SECONDARY)

(Signed)

Sept 15, 1915 (Address) 2031 W. O. Rutter

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. In the State yrs. mos. ds.

Where was disease contracted,

at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

2031 W. O. Rutter 2238 Frederick Ave

C88202 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2570 Wilkins Ave ST. 20 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Bridget P. Bleicher(Residence in Baltimore: No. 2570 Wilkins Ave St. 50 yrs. 50 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX. <u>Female</u>	4-COLOR OR RACE, <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <u>widowed</u> (Write the word.)
--------------------	-------------------------------	--

-DATE OF BIRTH, <u>about</u> , <u>1858</u> (Month) (Day) (Year)	-AGE, <u>57</u> yrs. mos. ds.	If LESS than 1 day, ...hrs. or...min.?
--	----------------------------------	---

-OCCUPATION: (a) Trade, profession, or particular kind of work... <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)...

-BIRTHPLACE, (State or Country), <u>Ireland</u>

10-NAME OF FATHER, <u>John Armstrong</u>
--

11-BIRTHPLACE OF FATHER (State or Country), <u>Ireland</u>
--

12-MAIDEN NAME OF MOTHER, <u>Mary Fitzpatrick</u>

13-BIRTHPLACE OF MOTHER (State or Country), <u>Ireland</u>
--

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Mary Armstrong(Address) 2570 Wilkins Ave

5-SIGNED, <u>ROBERT KRAUTER</u> , 15 1915, 191. <u>BURIAL PERMIT Clerk</u> Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, <u>September</u> , <u>13</u> , <u>1915</u> (Month) (Day) (Year)
--

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1915, to Sept 13 1915, that I saw her alive on Sept 13 1915, and that death occurred, on the date stated above, at 10:40 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cordiac Velatation

(Duration) <u>7</u> yrs. <u>7</u> mos. <u>7</u> ds.

CONTRIBUTORY. <u>Cholera Intestinal</u> (Secondary)
--

(Signed) <u>Robert C. Netter</u> , M. D. <u>Sept 13</u> , 1915 (Address) <u>2500 Adelphi St.</u>

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds.	In the State... yrs. ... mos. ... ds.
--	---------------------------------------

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, <u>New Cathedral</u>	DATE OF BURIAL, <u>Sept 16</u> , 1915.
---	--

20-UNDERTAKER, <u>Wm. M. Sawthrop</u>	ADDRESS, <u>1624 N. Royal Ave</u>
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C88203

HEALTH DEPARTMENT-CITY OF BALTIMORE

C88203

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15

SEP 15 1915

ROBERT J. KRAUTER

Baltimore Health Officer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

June 23, 1915, to Sept 13, 1915.

that I saw her alive on Sept 13, 1915.

and that death occurred, on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 6 wks. yrs. mos. ds.

Contributory
(SECONDARY)

(Signed) [Signature] M.D.

Sept 15, 1915 (Address) 11008 Cathedral Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park

Sept 16, 1915

20-UNDERTAKER

ADDRESS

Ed. Widfeldt Green Mt. Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *614 N Lakewood Ave.* ST. *7*)

2-FULL NAME

John T. Raley

(Residence in Baltimore: No. *614 N Lakewood Ave*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 10, 18*66*
(Month) (Day) (Year)

7-AGE,

49 yrs. *5* mos. *3* ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Salesman
unknown

9-BIRTHPLACE,
(State or Country),

MD

10-NAME OF FATHER,

John M. Raley

11-BIRTHPLACE OF FATHER
(State or Country),

MD

12-MAIDEN NAME OF MOTHER

Alexandra Marshall

13-BIRTHPLACE OF MOTHER
(State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Fannie Raley

(Address) *614 N. Lakewood Ave.*

15-

SEP 15 1915

ROBERT KRAUTER,

Filed

1915

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 13, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*
(Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Suicide) Pistol shot wound in head

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Elyah J. Russell* M. D.

Sept 14, 191*5* (Address) *412 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

Sept 16, 191*5*

20-UNDERTAKER

Christian Miller

ADDRESS

233 E. Jefferson St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3030 Elliott ST.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Stez(Residence in Baltimore: No. 3030 Elliott St.; 35 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

-SEX. Male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
(Write the word.)

-DATE OF BIRTH, June 24, 1865
(Month) (Day) (Year)

-AGE, 50 yrs., 2 mos., 26 ds. If LESS than 1 day,hrs. or....min.?

-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

-BIRTHPLACE, (State or Country), Austria Poland

10-NAME OF FATHER, John Stez

11-BIRTHPLACE OF FATHER (State or Country), Austria Poland

12-MAIDEN NAME OF MOTHER Annie Imier

13-BIRTHPLACE OF MOTHER (State or Country), Austria Poland

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Stez
(Address) 3030 Elliott St

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 14, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 17 1915, to Sept. 13 1915, that I saw him alive on Sept. 13 1915, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
(Duration) About 1 yrs., mos., ds.

CONTRIBUTORY (Secondary) Asthma

(Signed) Henry B. Hether M. D.
9/15, 1915 (Address) 200 N. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Sept. 16, 1915

20-UNDERTAKER

M. J. Sadowicki

ADDRESS

405 S. Ann

SEP 15 1915

ROBERT J. BRAUTER,

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1536 H. Gilmore*)ST.: *15* WARD)

REGISTERED NO. C

2-FULL NAME *Chas. W. Ellender*(Residence in Baltimore: No. *1536 H. Gilmore*)

St.: ... yrs., ... mos. ... da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, (Write the word.) *Married*

DATE OF BIRTH,

March 1, 1876

(Month)

(Day)

(Year)

AGE,

*39**6*

yrs. ... mos. ... ds.

If LESS than 1 day,

... hrs. or ... min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work, *Auditor*(b) General nature of industry, business, or establishment in which employed (or employer), *BROTHER*

BIRTHPLACE, (State or Country),

Balto, Md.

10-NAME OF FATHER,

Chas. F. Ellender

11-BIRTHPLACE OF FATHER (State or Country),

Balto, Md.

12-MAIDEN NAME OF MOTHER

Sarah E. Rollins

13-BIRTHPLACE OF MOTHER (State or Country),

Balto, Md.

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

H. Ellender

(Address),

1512 Harlem Ave.

SEP 15 1915

HARRY O. ANDREWS,

191. Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH,

Sept. 14, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 23, 1915, to Sept. 14, 1915.*that I saw him alive on *Sept. 13, 1915,*and that death occurred, on the date stated above, at *940 a. m.*

The CAUSE OF DEATH* was as follows:

*General Tuberculosis**acute*

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *G. Lakshmi Ewalt* M. D.*Sept. 14, 1915* (Address) *105 H. Gilmore St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Greenwood Cemetery *Sept. 16, 1915.*

20-UNDERTAKER ADDRESS

Robert L. Turner *Brooklyn Ave.*

C88207

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88207

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *2009 E Federal* ST.; *8* WARD)2-FULL NAME *Ella Collins*(Residence in Baltimore: No. *2009 E Federal* St.; *43* yrs., *11* mos., *15* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

DATE OF BIRTH, *Sept 29th*, 18*72*
(Month) (Day) (Year)

AGE, *42* yrs., *11* mos., *15* ds. If LESS than 1 day, hrs. or min.?

OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer).

BIRTHPLACE, (State or Country), *City*

10-NAME OF FATHER, *Albert Allard*

11-BIRTHPLACE OF FATHER (State or Country), *Md*

12-MAIDEN NAME OF MOTHER *Ann E.*

13-BIRTHPLACE OF MOTHER (State or Country), *Md*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank E. Allard*

(Address) *2009 E Federal*

SEP 15 1915

HARRY G. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *Sept 14*, 19*15*.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Sept 1* 1914, to *Sept 13* 1915, that I saw her alive on *Sept 13* 1915, and that death occurred, on the date stated above, at *11* a.m.

The CAUSE OF DEATH was as follows:

Coronary Sclerosis
(Duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary) *Exhaustion*

(Signed) *Geo. J. Young* M. D.
Sept 14, 1915 (Address) *1531 E. Federal*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Oak Lawn *Sept 17*, 1915

20-UNDERTAKER ADDRESS *2016*

Philip Herwig *Orleans*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. *St. Johns Hopkins Hospital*ST. *1*

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Katia Balkowski

(Residence in Baltimore: No.

*4205 Duncan St.*St. *14* yrs. — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

DATE OF BIRTH

1880
(Month) (Day) (Year)

AGE

*about**35* yrs. — mos. — da.

If LESS than 1 day,

...hrs. or ...min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House wife
*at home*BIRTHPLACE,
(State or Country),*Russia*

10-NAME OF FATHER

*Michael Baginski*11-BIRTHPLACE OF FATHER
(State or Country),*Russian Poland*

12-MAIDEN NAME OF MOTHER

*Not Known*13-BIRTHPLACE OF MOTHER
(State or Country),*Not Known*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

S. Roszel

(Address)

St. Johns Hopkins Hosp.

5-

SEP 15 1915

Regd.

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept. 14, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Sept 10 1915, to *Sept 14* 1915,
that I saw her alive on *Sept 14* 1915,
and that death occurred, on the date stated above, at *10.10* a.m.

The CAUSE OF DEATH* was as follows:

Acute Leukemia(Duration) ... yrs. ... mos. *4* da.CONTRIBUTORY (Secondary) *Chronic Relapsing Inf. Dis. Acute*Pendant: 2 (Duration) ... yrs. ... mos. *10* da.(Signed) *Lawrence R. Wharton*, M. D.*Sept. 14* 1915 (Address) *St. Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. *4* da. In the *14* yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence *4205 Duncan Street*

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary

DATE OF BURIAL

Sept 16 1915

20-UNDERTAKER

William Fialkowski

ADDRESS

*1618 Eastern**ave*

C88209

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88209

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *426 E. Cager*)ST. *10* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore, No. *426 E. Cager*)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, OR DIVORCED *Married*
(Write the word.)

6-DATE OF BIRTH

March 1872
(Month) (Day) (Year)

7-AGE

43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Nurse-keeper*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Josephine Midgeville*(Address) *426 E. Cager St.*

MEDICAL CERTIFICATE OF DEATH.

15-DATE OF DEATH

September 14, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

April 10, 1915 to *Sept. 14, 1915*

that I saw him alive on *Sept. 14, 1915*and that death occurred, on the date stated above, at *7:20* m.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *George F. ...* M. D.

191... (Address) *...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Registrar

SEP 15 1915

191...

St. Vincent's Cem
Chas. P. Coates & Son 1810 N. Royal

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH *University Hosp.* 16
 CITY OF BALTIMORE, (No. *University Hosp.* ST.; *16* WARD)
 FULL NAME *Baby Thomas*
 (Residence in Baltimore: No. *1421* *Monk St.* St.; *1421* yrs., *1421* mos., *1421* da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX. *Male* 4-COLOR OR RACE, *Black* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
 (Write the word.)
 DATE OF BIRTH, *9-10-1915*
 (Month) (Day) (Year)
 AGE, *0* yrs., *0* mos., *0* ds. If LESS than 1 day, *12* hrs. or *2* min.?

OCCUPATION:
 (a) Trade, profession, or particular kind of work. *None*
 (b) General nature of industry, business, or establishment in which employed (or employer). *None*

BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Samuel Lee*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER *Maggie Thomas*

13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. L. Rush M.D.*
 (Address) *University Hosp.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *9-10-1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *9-10-1915*, to *9-10-1915*, that I saw him *live* on *9-10-1915*, and that death occurred, on the date stated above, at *10 P.M.* The CAUSE OF DEATH* was as follows:

Prematurity (from fetus)
 (Duration) *0* yrs., *0* mos., *0* ds.

CONTRIBUTORY (Secondary) (Duration) *0* yrs., *0* mos., *0* ds.

(Signed) *P. L. Rush M.D.*
9-10-1915, 1915. (Address) *University Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *0* yrs., *0* mos., *0* ds. In the State *0* yrs., *0* mos., *0* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL, *Sept. 11, 1915*

20-UNDER-TAKER *Comptroller Health* ADDRESS

SEP 15 1915

HARRY O. ANNE UNIVERSITY OF MARYLAND

Regist. *1915* Marital Permit *Clark* Registrar.

FOR ANATOMICAL PURPOSES.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 28.)

2-FULL NAME

(Residence in Baltimore: No. *1024 E. Lombard St.* St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)

6-DATE OF BIRTH, *July 10*, 1915
(Month) (Day) (Year)

7-AGE, *2* yrs., *2* mos., *10* da. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *md.*

10-NAME OF FATHER, *Dominic Michael*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER *"*

13-BIRTHPLACE OF MOTHER (State or Country), *"*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Phelps*(Address) *Johns Hopkins Hospital*

SEP 15 1915

HARRY O. JONES

Social Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 10*, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Sept. 7* 1915 to *Sept. 10* 1915 that I saw him alive on *Sept. 10*, 1915 and that death occurred, on the date stated above, at *3:30 p.m.*

The CAUSE OF DEATH was as follows:

Des. or. illis.
(Duration)..... yrs..... mos. *14* ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.
(Signed) *Edward A. Bahr*
Sept. 11, 1915 (Address) *Johns Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos. *3* ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? *✓*Former or usual residence *1024 E. Lombard St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

HARRY O. JONES

Social Permit Clerk

20-UNDERTAKER

Commissioner of Health.

ADDRESS

FOR ANATOMICAL PURPOSES.

88212

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 444 N. Linwood St. WARD 6)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina Borgmann(Residence in Baltimore: No. 444 N. Linwood Ave. St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)DATE OF BIRTH, October 8th, 1842
(Month) (Day) (Year)AGE, 72 yrs., 11 mos., 7 ds. If LESS than 1 day, hrs. or min.?OCCUPATION:
(a) Trade, profession, or particular kind of work, House work
(b) General nature of industry, business, or establishment in which employed (or employer), at homeBIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, Unknown11-BIRTHPLACE OF FATHER (State or Country), Unknown12-MAIDEN NAME OF MOTHER, Unknown13-BIRTHPLACE OF MOTHER (State or Country), Unknown

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Geo. Darrington(Address) 444 N. Linwood Ave.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 15, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 8th 1915, to Sept 15 1915, that I saw her alive on Sept 15 1915, and that death occurred, on the date stated above, at 4:08 a.m.

The CAUSE OF DEATH* was as follows:

Sarcoidosis
Chronic Infectious Tuberculosis
(Duration) 2 yrs., — mos., — ds.CONTRIBUTORY (Secondary) Id. exp.
(Duration) — yrs., — mos., — ds.(Signed) E. T. Meyer M. D.
Sept 15, 1915. (Address) 1017 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Mathew CemeteryDATE OF BURIAL, Sept 17, 191520-UNDERTAKER, Christian MillerADDRESS, 2334 Jeffers

SEP 15 1915

HARRY G. ANDERSON

Registrar.

C88213

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88213

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 E. Madison ST.)

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1502 E. Madison

St.: 18 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Jan 20, 1896
(Month) (Day) (Year)

7-AGE,

19 yrs. 7 mos. 14 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... School Boy

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP 15 1915

HARRY O. ANDREWS,

Berial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sep 13, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 12, 1915, to Sept 13, 1915,

that I saw him alive on Sept 13, 1915,

and that death occurred, on the date stated above, at 7:45 p.m.

The CAUSE OF DEATH* was as follows:

Peritoneal Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 7 mos. ds.

(Signed) Dr. H. J. Townsend, M.D.

(Address) 1019 N. Howard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel Cemetery

Sept 16, 1915

20-UNDERTAKER

Chas. B. Bailey

ADDRESS

Jefferson

C88214

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88214

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

811 Low St.

ST.

WARD)

REGISTERED NO. C

FULL NAME

Adulinda Taucous

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

811 Low St.

St.; yrs., 9 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female.

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Child

6-DATE OF BIRTH,

December 3, 1914
(Month) (Day) (Year)

7-AGE,

yrs. 9 mos. 12 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Child.

9-BIRTHPLACE,
(State or Country),

Italy

10-NAME OF FATHER,

Rocco Taucous.

11-BIRTHPLACE OF FATHER

(State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Louisa De Nicola

13-BIRTHPLACE OF MOTHER

(State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rocco Taucous

(Address) 811 Low St.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 13, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, to find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsion. Heart prostration.

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Frankish, M. D.

Sept. 15, 1915 (Address) 18 N. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeem. Cm.

DATE OF BURIAL,

Sept 16, 1915

20-UNDERTAKER

Lily & Zile

ADDRESS

403 E. 11th

SEP 15 1915

HARRY O. ANDREWS,

Filed, 191... Serial... Registrar.

C88215

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88215

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX

4-COLOR OR RACE

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

16-DATE OF DEATH

17.

I HEREBY CERTIFY, That I attended deceased from

July 10, 1915, to September 13, 1915.

that I saw him alive on September 13, 1915,

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Parachymatous
Nephritis

(Duration) 2 yrs. 4 mos. — ds.

Contributory
(SECONDARY)

(Signed)

Sept 14, 1915 (Address) 1328 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

15.

Filed

SEP 15 1915

HARRY O. ANDERSON,

Registrar

Western Cemetery

Sept 16, 1915

Geo A Gerbig

Baltimore

C88213

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88216

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2043 Ellsworth St.*;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Ana V. Rehm*(Residence in Baltimore: No. *2043 Ellsworth*

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

June

(Month)

5

(Day)

1915

(Year)

7-AGE,

3

yrs.

10

mos.

10

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Balto Md*

10-NAME OF FATHER

*Harry Rehm*11-BIRTHPLACE OF FATHER
(State or Country),*Balto Md*

12-MAIDEN NAME OF MOTHER

*Sarah V. Fulton*13-BIRTHPLACE OF MOTHER
(State or Country),*Balto Md*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harry Rehm

(Address)

2043 Ellsworth St.

15-

SEP 15 1915

191

HARRY O. ANDREWS

BAPTIST FORMERLY OF BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 15

(Month)

(Day)

15

(Year)

17-HEREBY CERTIFY, That I attended deceased from *Sept 14* 1915, to *Sept 15* 1915,that I saw her alive on *Sept 15* 1915,and that death occurred, on the date stated above, at *7 A.M.*

The CAUSE OF DEATH* was as follows:

*Marasmus*CONTRIBUTORY
(Secondary)*Asthma**William Francis**Sept 15* 1915

(Address)

1447 N. 9th

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Mrs. Carmel Connelley**Sept 16* 1915

20-UNDERTAKER

ADDRESS

*Henry Lutz**1007 N. Bond*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88217

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 S. Durham ST.; 79 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Hamill(Residence in Baltimore: No. 123 S. Durham st St.; 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX. Female4-COLOR OR RACE, White5-STATUS, married
MARRIED,
WIDOWER,
OR DIVORCED.
(Write the word.)-DATE OF BIRTH, Oct. 13th, 1868.

(Month)

(Day)

(Year)

-AGE, 46 yrs., 11 mos., 1 ds.If LESS than 1 day,
...hrs. or...min.?

-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

-BIRTHPLACE,

(State or Country), Howard County Md10-NAME OF FATHER, John Kane11-BIRTHPLACE OF FATHER (State or Country), Howard County Md12-MAIDEN NAME OF MOTHER unmarried13-BIRTHPLACE OF MOTHER (State or Country), Howard County Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Spang Hamill(Address) 123 S. Durham st

15-

SEP 15 1915

HARRY O. ANDREWS

Marial Permit Clerk

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 14th, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13, 1915, to Sept 14, 1915, that I saw her alive on Sept 14th, 1915, and that death occurred, on the date stated above, at 10³⁰ AM

The CAUSE OF DEATH* was as follows:

Mitral Stenosis & Insufficiency
(Duration) ? yrs., — mos., — ds.CONTRIBUTORY (Secondary) Acute Indigestion(Duration) 4 yrs., — mos., — ds.(Signed) Harry Goldsmith M. D.
9/14/1915, 1915. (Address) 1739 E. Pratt st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore CemeteryDATE OF BURIAL, Sept. 16, 1915

20-UNDERTAKER

H. E. Hughes

ADDRESS

17 S. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *509 N Carey* ST. *18* WARD)2-FULL NAME *Annie Gertrude Reep*(Residence in Baltimore: No. *509 N Carey* St.: yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH *Oct 29, 1852* (Month) (Day) (Year)7-AGE *62* yrs. *8* mos. *15* ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *James Garth*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER *Mary Barrington*13-BIRTHPLACE OF MOTHER (State or Country), *Phile Pa*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr J H Reep*(Address) *509 N Carey*

SEP 16 1915

ROBERT

KRAUTER

Filed....., 1915

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *Sept 14, 1915* (Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Sept 11, 1915*, to *Sept 14, 1915*, that I saw her alive on *Sept 14, 1915*, and that death occurred, on the date stated above, at *7 P. M.*

The CAUSE OF DEATH* was as follows:

*Arteriosclerotic Bright's*CONTRIBUTORY (Secondary) *Arteriosclerotic* (Duration) *2* yrs. *2* mos. *2* ds.(Signed) *William E. Reep* M. D. *9/15/15, 1915* (Address) *762 W. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Green Mount*DATE OF BURIAL, *9-16-15, 1915*

20-UNDERTAKER

*H C Brauning & Son*ADDRESS *517 N. S. Schneider*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1310 Holbrook* ST.; *9* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Frances E. Haldner*(Residence in Baltimore: No. *1310 Holbrook* ST.; *9* WARD)St.; *9* yrs., *6* mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female.

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH,

March 9, 1915
(Month) (Day) (Year)

7-AGE,

6 yrs., *6* mos., *6* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*nurse*9-BIRTHPLACE,
(State or Country),*Balto. Md*

10-NAME OF FATHER,

*Charles H. Haldner*11-BIRTHPLACE OF FATHER
(State or Country),*city*

12-MAIDEN NAME OF MOTHER

*Ethel Jett*13-BIRTHPLACE OF MOTHER
(State or Country),*Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

M. Charles H. Haldner

(Address)...

1310 Holbrook St

15-

SEP 16 1915 ROBERT KRAUTER,
FROD. *Funeral Permit Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 15, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Sept. 13, 1915*, to *Sept. 15, 1915*, that I saw her alive on *Sept. 14, 1915*, and that death occurred, on the date stated above, at *5:29* p.m.

The CAUSE OF DEATH* was as follows:

choera infantum(Duration).....yrs.....mos. *2* ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....*W. E. Rogers, M. D.**Sept. 15, 1915* (Address).....*1206*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

Sept. 16, 1915

20-UNDERTAKER

Henry Hockley

ADDRESS

1301 E. Eager St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88220

CERTIFICATE OF DEATH.

152 C88220
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1750 N. ChesterST. 8

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine ChilcoatResidence in Baltimore: No. 1750 N. Chester

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX, <u>Female</u>	4-COLOR OR RACE, <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Single</u>
DATE OF BIRTH, <u>Sept 15</u> , <u>1915</u> (Month) (Day) (Year)		
AGE, yrs. mos. ds.		If LESS than 1 day, <u>7 hrs. or 30 min.?</u>
OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer)..... <u>None.</u>		
BIRTHPLACE, (State or Country), <u>Ba. Md.</u>		
10-NAME OF FATHER, <u>Melvin Chilcoat</u>		
11-BIRTHPLACE OF FATHER (State or Country), <u>Md.</u>		
12-MAIDEN NAME OF MOTHER <u>Josephine Smith</u>		
13-BIRTHPLACE OF MOTHER (State or Country), <u>Md.</u>		

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Melvin Chilcoat(Address) 1750 N. Chester St.

5-

SEP 16 1915
 HOBERT KRAUTER,
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15, 1915, to Sept 15, 1915, that I saw her alive on Sept 15, 1915, and that death occurred, on the date stated above, at 8:4 m. The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum.

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... James C. Fisher..... M. D.Sept 15, 1915. (Address)..... 1926 E. Lofo

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western CemeteryDATE OF BURIAL, Sept 16, 191520-UNDERTAKER Henry HouchADDRESS 1301 E. Engle

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1423 Mosher* ST.; *16* WARD)

2-FULL NAME

Alberta Elizabeth Pratt(Residence in Baltimore: No. *1423 Mosher* St.; *whole life* yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

*March**11**1884*

(Month)

(Day)

(Year)

7-AGE,

31

yrs., mos., ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Domestic*(b) General nature of industry, business, or establishment in which employed (or employer), *General house work*

9-BIRTHPLACE, (State or Country),

Balto. City

10-NAME OF FATHER,

Monroe Bailey

11-BIRTHPLACE OF FATHER (State or Country),

Petersburg Va.

12-MAIDEN NAME OF MOTHER

Jane Charity

13-BIRTHPLACE OF MOTHER (State or Country),

Petersburg Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Hattie Bailey

(Address)...

747 W. Franklin St.

SEP. 16 1915

ROBERT

KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Sept.**17**1915*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

*Sept. 6 1915*to *Sept. 13 1915*that I saw her alive on *Sept. 13 1915*and that death occurred, on the date stated above, at *8:10 p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary septicaemia

(Duration)

about 12 hours

CONTRIBUTORY (Secondary)

Retained placenta & surgical shock

(Duration)

24 hours

(Signed)...

*Chas. L. McFarland M. D.**Sept. 14, 1915*(Address) *906 N. Street N.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

Int. Auburn

DATE OF BURIAL,

Sept. 16 1915

20-UNDERTAKER

John H. Travers

ADDRESS

142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (NO.)

2-FULL NAME

(Residence in Baltimore: No.)

University Md Hosp St. 18
Peter Rameikis
841 W Lombard

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX, male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word)

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 25 yrs. mon. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Parlor (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

10-NAME OF FATHER, Anton Rameikis

11-BIRTHPLACE OF FATHER, (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Francis Lutkewicz

13-BIRTHPLACE OF MOTHER, (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anne Rameikis

(Address) 841 W Lombard St

15- SEP 16 1915 ROBERT ZRAUTER, Registrar

Filed, 101, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 14, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull (accidental)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fell from 2nd story

(Duration) yrs. mos. ds.

Signed, J. J. Jeffers M. D. Coroner

Sept 13 1915 (Address) 413 N Carrollton

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, 9 yrs. mos. ds. In the 8 yrs. mos. ds. State, 8 yrs. mos. ds.

Where was disease contracted, if not at place of death? 841 W Lombard

Former or usual residence, 841 W Lombard

19-PLACE OF BURIAL OR REMOVAL, St Stanislawas DATE OF BURIAL, Sep 17, 1915

20-UNDERTAKER, John Greliauskas ADDRESS, 500 S. Paca St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 N. Charles ST. 12 WARD)2-FULL NAME Geo. William Squiggins(Residence in Baltimore: No. 1821 N. Charles St. St.: - yrs. 9 mos. 6 ds.)REGISTERED NO. C. 104

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Single

6-DATE OF BIRTH

December
(Month)9
(Day)1914
(Year)

7-AGE

9 yrs.6 mos.6 ds.If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)none9-BIRTHPLACE
(State or country)Baltimore - Md.

10-NAME OF FATHER

Edward Kirk Squiggins11-BIRTHPLACE OF FATHER
(State or country)Ohio -

12-MAIDEN NAME OF MOTHER

Gertrude L. Sanders13-BIRTHPLACE OF MOTHER
(State or country)Baltimore - Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Kirk Squiggins

(Address)

1821 N. Charles St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Birth - 12/9, 1914, to, Sept 15, 1915.that I saw him alive on Sept 15, 1915.and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration)

4 hours

yrs.

mos.

ds.

Contributory
(SECONDARY)Probably acute indigestion
Gastritis

(Duration)

yrs.

mos.

ds.

(Signed),

W. J. Dalton M. D.Sept 15, 1915 [Address]720 W. North Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cudon Park Cemetery

DATE OF BURIAL

Sept. 16, 1915

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 West
Baltimore St.

mailed 2594

15-

SEP 16 1915

ROBERT I. KRAUTER

Burial Permit Officer

REGISTRAR

91

REGISTERED No. C

14

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. (da.)

CORONER'S CERTIFICATE OF DEATH.

5-SINGLE,
MARRIED, **single,**
WIDOWED,
OR DIVORCED.
(Write the word.)

February.....4th., 1915.
(Month) (Day) (Year)

If LESS than 1 day,
....hrs. or....min.?

None.

Baltimore, Md.

10-NAME OF
FATHER, Samuel Hall.

11-BIRTHPLACE
OF FATHER
(State or Country), Pennsylvania.

12-MAIDEN NAME
OF MOTHER Bertie Mooney

13-BIRTHPLACE
OF MOTHER
(State or Country), Maryland.

(Informant) .. Bertie Hall .. mother

(Address).....2308..Division..street.....

15-
SEP 16 1915
MOBERT, KRAUTH
File... 101...
Registrar.

September...15th 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the
remains described above, held an inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-
...inquiry...and that said deceased came to his death
topsy or inquiry.)
on the day stated above.

.....Branchopneumonia.....

(Duration).....yrs.....mos. 7.....da.

CONTRIBUTORY.....
(Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) J. Frederick Campbell M. D.
(Coroner)

Sept. 16, 1915 (Address) 3310 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

TO PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.

20-UNDERTAKER	ADDRESS
---------------	---------

James H. Dennis / 30 West

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1518 7th Spring* ST.: *8* WARD)2-FULL NAME *Caroline A. Rastner*(Residence in Baltimore: No. *1518 7th Spring* St.: *Life* yrs., mos., da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX *Female*4-COLOR OR RACE *White*SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*DATE OF BIRTH *Oct 12*, 1897

(Month)

(Day)

(Year)

AGE, *17* yrs., *11* mos., *3* ds.

If LESS than 1 day,

...hrs. or...min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*(b) General nature of industry, business, or establishment in which employed (or employer) *None*BIRTHPLACE, (State or Country), *Latvia*10-NAME OF FATHER, *Ignatius Rastner*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Theresa Keller*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Theresa Rastner*(Address) *1518 7th Spring*

SEP 16 1915

Filed..... 1915

ROBERT

KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 15*, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 5*, 1913, to *Sept 15*, 1915,that I saw him alive on *Sept 15*, 1915,and that death occurred, on the date stated above, at *9 p.* m.

The CAUSE OF DEATH* was as follows:

Pneumonia Pulmonalis(Duration) *2* yrs., *1* mos., *1* ds.CONTRIBUTORY.....*Exhaustion*

(Secondary)

(Duration) *2* yrs., *1* mos., *1* ds.(Signed) *Howard E. Hodges* M. D.*Sept 16*, 1915 (Address) *530 E. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs., *1* mos., *1* ds. In the State *1* yrs., *1* mos., *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1518 7th Spring*19-PLACE OF BURIAL OR REMOVAL, *Polk Cemetery* DATE OF BURIAL, *Sept 18*, 191520-UNDERTAKER *Robt Turner*ADDRESS *1842 4th Bway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2025 Ellsworth St.; 8 WARD)
2-FULL NAME Chas H A Gabel
(Residence in Baltimore: No. 2025 Ellsworth St.; 40 yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married
DATE OF BIRTH Jan 30, 1847
(Month) (Day) (Year)
AGE 68 yrs., 7 mos., 14 ds. If LESS than 1 day,hrs. or....min.
OCCUPATION:
(a) Trade, profession, or particular kind of work Müller
(b) General nature of industry, business, or establishment in which employed (or employer) Iron
BIRTHPLACE, (State or Country), Germany
10-NAME OF FATHER, Chas Gabel
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER Dora Müller
13-BIRTHPLACE OF MOTHER (State or Country), Germany

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

SEP 16 1915

ROBERT K. KRAUTER,

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1910, to Sept 13 1915, that I saw him alive on Sept 13 1915, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Aortic sclerosis
Hypertension
(Duration) 6 yrs., mos., ds.

CONTRIBUTORY Aedema of Brain
(Secondary) (Duration) several days

(Signed) Wm H. Deland M.D.
Sept 16 1915 (Address) 1819 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St. Louis DATE OF BURIAL, Sept 15 1915

20-UNDERTAKER

ADDRESS

St. Louis 1442 N. Bond

Beatha A Price
 088227 HEALTH DEPARTMENT—CITY OF BALTIMORE 088227

170
 CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

DATE OF BIRTH,

AGE,

If LESS than 1 day,

OCCUPATION:

(a) Trade, profession, or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer).

BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on and that death occurred, on the date stated above, at

The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Signed) (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *2552 Druid Hill an* 13

2-FULL NAME

(Residence in Baltimore: No. *2552 Druid Hill an*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *unmarried*

6-DATE OF BIRTH, *about* 1844 (Month) (Day) (Year)

7-AGE, *71* yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *None* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Ireland*

10-NAME OF FATHER, *John Bayton*

11-BIRTHPLACE OF FATHER (State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER *Mary Hughes*

13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Ella Yeager*

(Address) *2552 Druid Hill an*

15-SEP 16 1915 ROBERT KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 15*, 1915. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said *inquiry* find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Arteriosclerosis (?)*

(Duration) yrs. mos. ds.

(Signed) *Frank C. Rogers* M.D. (Coroner)

Sept 15, 1915. (Address) *3646 Roland*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *New Cathedral*

DATE OF BURIAL, *Sept 18*, 1915

20-UNDERTAKER, *Wm. G. Gault*

ADDRESS *1624*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

ST.

WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWER,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

Apr. 30, 1858
(Month) (Day) (Year)

7-AGE,

57 yrs. 4 mos. 14 ds.

If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Clerk
office work

9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

Carl Stange

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Wilhemina Dargatz

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP 16 1915

ROBERT J. KRAUTH

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 14, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull
(Accidental)
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Signed) J. J. Jeffers M. D.
(Coroner)
Sept 15, 1915 (Address) 1137 Canastota Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Munton Ave + York Rd
Former or usual residence 5 Munton Ave

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

Sept 16, 1915

20-UNDERTAKER

Wm. L. ...

ADDRESS

104 E. ...

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C88230

152 C88230

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2219 N. Calver St. ST. 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

FULL NAME Child of Geo. W. & Grace J. RothResidence in Baltimore: No. 2219 N. Calver St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word.)MalewhiteSingle

DATE OF BIRTH,

Sept 16, 1915
(Month) (Day) (Year)

AGE,

If LESS than 1 day,

..... yrs. mos. ds.

.... hrs. or 20 min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....childBIRTHPLACE,
(State or Country),Balto Md

10-NAME OF FATHER,

Geo W Roth

11-BIRTHPLACE OF FATHER

(State or Country), Balto Md

12-MAIDEN NAME OF MOTHER

Grace J. Mitchell

13-BIRTHPLACE OF MOTHER

(State or Country), Balto

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Geo W Roth(Address), 2219 N. Calver

5-

SEP 16 1915

ROBERT KRAUTH

Municipal Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

9, 16, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 15, 1915, to Sept 16, 1915,that I saw him alive on Sept 16, 1915,and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

asphyxiated in birth

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed), Edmund J. [illegible], M. D.9/16, 1915. (Address) 210. [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Louisa Park, Sept 15, 1915.

20-UNDERTAKER

ADDRESS

Wm Croft, 5018 North

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1535 Holbrook ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. 1535 Holbrook St.; yrs. 2 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male White Single

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

6-DATE OF BIRTH,

Aug, 29, 1915
(Month) (Day) (Year)

7-AGE,

16 yrs. 16 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

SEP 16 1915

ROBERT KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

15-DATE OF DEATH,

Sept, 14, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 10 1915, to Sept 14 1915,that I saw him alive on Sept 14 1915,and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis
(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Signed) Wm Pearce M. D.
Sept 15, 1915 (Address) 5 E Preston

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Mary Cemetery Sept 16 1915

20-UNDERTAKER

ADDRESS

Mr J. E. Evans 1428 Schrank
Sons St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *4* WARD)2-FULL NAME *Antone Pikey*(Residence in Baltimore: No. *University Hospital* St.; yrs. mos. *3* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*6-DATE OF BIRTH, *Nov. 3, 1894*

(Month)

(Day)

(Year)

7-AGE, *20* yrs. *10* mos. *17* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Farmer*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Geo. Pikey*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Josephine Zelma*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elmer Newcomer*(Address) *University Hospital*

SEP 16 1915

ROBERT

KRAUTER

Baptist Church

Registrar.

MEDICAL CERTIFICATE OF DEATH.

15-DATE OF DEATH, *Sept. 15, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept. 13, 1915*, to *Sept. 15, 1915*, that I saw him alive on *Sept. 15, 1915*, and that death occurred, on the date stated above, at *7:20 P. M.*

The CAUSE OF DEATH* was as follows:

Punctured wound of the chest caused by a nail.(Duration) yrs. mos. *5* ds.CONTRIBUTORY (Secondary) *Acute Tetanus*(Duration) yrs. mos. *3* ds.(Signed) *Elmer Newcomer*(Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSFERS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death? *Elkridge Md*Former or usual residence *Elkridge Maryland*19-PLACE OF BURIAL OR REMOVAL, *St Mary's Cemetery*DATE OF BURIAL, *Sept. 17, 1915*20-UNDERTAKER *Eaton Sons*ADDRESS *Elkridge City*

88233

HEALTH DEPARTMENT—CITY OF BALTIMORE

88233

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 22 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; — yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Dec

6

1866

(Month)

(Day)

(Year)

7-AGE,

48

9

10

ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Washington DC

10-NAME OF FATHER,

Wm Crauford

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Mary Lewis

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

Filed.

SEP 16 1915

WILLIAM KRAUER,

191. Special Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 16, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 14 1915 to Sept 16 1915

that I saw him alive on Sept 16 1915

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

CONTRIBUTORY (Secondary)

Operative and

diaphragmatic fistula

(Signed) W. E. Bondy M. D.

Sept 16, 1915. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. 1 mos. 2 ds. In the State, yrs. 1 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 600 Columbia Ave

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Washington DC SEP 16 1915

20-UNDERTAKER

Henry Lutz

ADDRESS

1007 St Bonnet

C88234

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88234

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

417 Druid Hill Ave

ST.: 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Elizabeth Brown

(Residence in Baltimore: No.

417 Druid Hill Ave

St.:

yrs. 5 mos. 0 da.)

PERSONAL AND STATISTICAL PARTICULARS.

-SEX. Female	4-COLOR OR RACE, Blk-	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single
-DATE OF BIRTH, April 9 th , 1915 (Month) (Day) (Year)		
-AGE, 5 mos. 6 da.		If LESS than 1 day, ...hrs. or...min.
-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). None		
-BIRTHPLACE, (State or Country), Baltimore - Md		
10-NAME OF FATHER, Harry Brown		
11-BIRTHPLACE OF FATHER (State or Country), Baltimore - Md		
12-MAIDEN NAME OF MOTHER Lizzie Lockley		
13-BIRTHPLACE OF MOTHER (State or Country), Virginia		

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Lizzie Lockley

(Address).....

633 Dolphin St

5-

Filed.....

SEP 16 1915

HARRY O. ANDERSON

1915 Permitted Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

September 15, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 14, 1915, to September 15, 1915, that I saw her alive on September 14, 1915, and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration).....yrs.....mos.....da.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....da.

(Signed).....Rutha E. Tapman.....M. D.

Sept. 16, 1915 (Address).....2733 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Auburn

DATE OF BURIAL,

Sept. 16, 1915

20-UNDERTAKER

John H Owens

ADDRESS

1122 Duval

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *678 W. Fayette*

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *678 W Fayette St*St.; *2* yrs. *2* mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

-SEX.

female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

widow

-DATE OF BIRTH

March 26, 1850
(Month) (Day) (Year)

-AGE,

65 yrs. 5 mos. 2 ds.

If LESS than 1 day.

...hrs. or ...min.?

-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

*Seamstress**Hochschild & Kohn Co*

-BIRTHPLACE,

(State or Country),

Pennsylvania

10-NAME OF

FATHER,

Levitt & F. Stafford

11-BIRTHPLACE

OF FATHER

(State or Country),

Pennsylvania

12-MAIDEN NAME

OF MOTHER

Caroline Thomas

13-BIRTHPLACE

OF MOTHER

(State or Country),

Pennsylvania

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Mrs. D. V. Ryan

(Address).....

678 W Fayette St

SEP 16 1915

HARRY O. ANDERSON,

1915. Sept. 16. 10:15. A.M. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 16, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 3, 1915*, to *September 16, 1915*, that I saw her alive on *September 14, 1915*, and that death occurred, on the date stated above, at *12:05 a.m.*

The CAUSE OF DEATH* was as follows:

Organic heart disease(Duration) *6* yrs. *6* mos. *2* ds.

CONTRIBUTORY (Secondary)

Hypertrophic atherosclerosis(Duration) *unknown* yrs. *6* mos. *2* ds.(Signed) *Chester Piland* M. D.*9-16-1915* (Address) *2532 Edmondson Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Landon Park Cemetery

DATE OF BURIAL,

Sept. 17, 1915

20-UNDERTAKER

R. & M. J. Flynn

ADDRESS

1452 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88236

C88236

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1128 Hanover St. 23 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1128 Hanover St. 20 yrs. 20 mos. 20 da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Apr. 25, 1880
(Month) (Day) (Year)

7-AGE, 35 yrs. 4 mos. 20 ds. If LESS than 1 day,hrs. ormin.?

OCCUPATION:

(a) Trade, profession, or particular kind of work. House-Wife

(b) General nature of industry, business, or establishment in which employed (or employer).

BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henrietta Buchheit(Address) 1128 Hanover

SEP 16 1915

HARRY O. ANDREWS,

Regist. 1915 Burial Permit Oler Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 14, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1915, to Sept 14 1915, that I saw him alive on Sept 14 1915, and that death occurred, on the date stated above, at 9:20 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis - Lungs(Duration) 8 yrs. 14 mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) 3 yrs. 3 mos. 3 ds.(Signed) Frank C. Higgins M. D.915, 1915 (Address) 1230 S. Black

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 20 yrs. 20 mos. 20 ds. In the State 20 yrs. 20 mos. 20 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mount Olivet Cemetery Sept. 17, 1915.

20-UNDERTAKER,

ADDRESS

H. M. Flynn 1925 Highland St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *814 Columbia* ST. *21* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *814 Columbia* St. *49* yrs., *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(If write the word.)

DATE OF BIRTH,

AGE,

IF LESS than 1 day,

OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

BIRTHPLACE,

(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

1-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

SEP 17 1915

ROBERT . KRAUTER,

Bureau Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

15,

1915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 3 1915, to Sept 15 1915,

that I saw her alive on Sept 15 1915,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Enteritis

Chronic

(Duration)..... yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

Exhaustion

(Duration)..... yrs. mos. 7 ds.

(Signed)

Sept 16, 1915

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mr Oliver Lee

Sept 17, 1915.

20-UNDERTAKER

Edna Cook

ADDRESS

Rt. No. 21

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2050 Bank ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Weiss(Residence in Baltimore: No. 2050 Bank St.; Life yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX <u>Female</u>	4-COLOR OR RACE, <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Widowed</u>
6-DATE OF BIRTH, <u>7</u> (Month) <u>16</u> (Day), <u>1855</u> (Year)		
7-AGE, <u>60</u> yrs., <u>7</u> mos., <u>0</u> ds. IF LESS than 1 day, ...hrs. or...min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work... (b) General nature of industry, business, or establishment in which employed (or employer).... <u>At Home</u>		
9-BIRTHPLACE, (State or Country), <u>Balto City</u>		
10-NAME OF FATHER, <u>E. G. G. G.</u>	11-BIRTHPLACE OF FATHER (State or Country), <u>unobtainable</u>	
12-MAIDEN NAME OF MOTHER, <u>unobtainable</u>	13-BIRTHPLACE OF MOTHER (State or Country), <u>unobtainable</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Martens(Address) 2050 Bank

SEP 17 1915

ROBERT KRAUTER,
Municipal Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
July 6 1913, to Sept 15 1915,
that I saw him alive on Sept 15 1915,
and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, hypertensive, cardiac,
myocardial infarction, & thrombosis of the
coronary arteries.(Duration) 7 yrs., 2 mos., 0 ds.CONTRIBUTORY (Secondary) Heart failure & chronic(Duration) 2 yrs., 2 mos., 0 ds.(Signed) Thos. A. Muthers M. D.10/16, 1915 (Address) 1421 E. North St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 7 yrs., 2 mos., 0 ds. In the State 7 yrs., 2 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy RedeemerDATE OF BURIAL, Sept 20, 1915

UNDERTAKER

ADDRESS

William Cook 502 E North

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Joseph Hospital 10 WARD)

REGISTERED NO. C

2-FULL NAME

Thomas Prince

(If death occurred in a hospital or institution, give its NAME instead of street and number; and fill out No. 18.)

(Residence in Baltimore: No.

811 N. Forrest St. -

St.; 60 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

widowed

DATE OF BIRTH,

Don't know, 1 (Month) (Day) (Year)

AGE

not 66 yrs. mos. ds.

If LESS than 1 day,hrs. or....min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laforen General

BIRTHPLACE, (State or Country),

England

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country),

England

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Prince

(Address) 811 Forrest St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 16, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1915, to Sept 16 1915, that I saw him alive on Sept 16 1915, and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

chronic interstitial nephritis
arteriosclerosis - not known - (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Edema
cardiac thrombosis (Duration) yrs. mos. ds.

(Signed) O. S. H. - M. D.

Sept 16, 1915 (Address) St. Joseph Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? not known -

Former or usual residence 811 N. Forrest St.

19-PLACE OF BURIAL OR REMOVAL,

Holy Cross

DATE OF BURIAL,

Sept 17 1915

20-UNDERTAKER

McLean Cook

ADDRESS

502 E North

SEP 17 1915

ROBERT J. KRAUTER,

Burial Permit Clerk

Registrar.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C88240

CERTIFICATE OF DEATH

C88240

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

Sr. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

(Month)

(Day)

(Year)

7-AGE

31

yrs.

mos.

ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

2nd Engineer

9-BIRTHPLACE
(State or country)

Sunderland Eng

10-NAME OF
FATHER

Unknown

11-BIRTHPLACE
OF FATHER
(State or country)

Unknown

12-MAIDEN NAME
OF MOTHER

Unknown

13-BIRTHPLACE
OF MOTHER
(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

British Consulate
Hutch Building

ROBERT J. KRAUTER,

Municipal Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 15, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 15, 1915, to, Sept 15, 1915.

that I saw him alive on Sept 15, 1915.

and that death occurred, on the date stated above, at 3.20 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

eighteen days (Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

Sept 15, 1915 (Address) 17. S. Gay St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Hill Cem

Sept 17, 1915

20-UNDERTAKER

ADDRESS

Jas J. Cook

1003 W. Belts

SEP 17, 1915

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 Little Walsh St. 14 WARD)

2-FULL NAME

Infant of Andrew & Theresa Valencia

(Residence in Baltimore: No. 1811 Little Walsh St. yrs. mos. dn.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and call out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Col

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Infant

6-DATE OF BIRTH

Sept 13, 1915

7-AGE

3 yrs. 3 mos. 3 ds. or mo.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE
(State or country)Balt Md
1811 Little Walsh

10-NAME OF FATHER

Andrew Valencia

11-BIRTHPLACE OF FATHER
(State or country)

Capo d'Istria

12-MAIDEN NAME OF MOTHER

Theresa Battaglier

13-BIRTHPLACE OF MOTHER
(State or country)

Capo d'Istria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Andrew Valencia

(Address)

1811 Little Walsh

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 16, 1915

17- I HEREBY CERTIFY, That I attended deceased from

Sept 15, 1915, to, Sept 16, 1915

that I saw her alive on Sept 16, 1915,

and that death occurred, on the date stated above, at 4:45 pm.

The CAUSE OF DEATH* was as follows:

Premature Birth 6-6 1/2 mos.

(Duration) yrs mos. ds.

Contributory
(SECONDARY)

(Duration) yrs mos. ds.

(Signed) Dr. J. H. M. D.

Sept 16, 1915 [Address] 1209 [Address]

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSMISSION, OR RECENT RESIDENTS]

At place of death yrs mos. ds. State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

New Bethel Mch

20-UNDERTAKER

J. H. M. D.

DATE OF BURIAL

Sept 17, 1915

ADDRESS

574 Wilson St

18-

SEP 17 1915

HOBART KRAUTER

OFFICIAL REGISTRAR

C88242

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 C88242
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

1913 Walbrook Ave. 15 ST. WARD)

2-FULL NAME

John George Heinlein

(Residence in Baltimore: No.

1913 Walbrook Ave. 14 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

Sept.

2, 1827

7-AGE

88

yrs.

mos.

13 ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

Produce Dealer

9-BIRTHPLACE
(State or country)

Germany

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eva M. Heinlein

(Address)

1913 Walbrook Ave.

15-

SEP 17 1915

Filed

ROBERT J. KRAUTER,
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept.

13

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 13, 1915, to Sept. 15, 1915.

that I saw him alive on Sept. 15, 1915.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis &
Chronic interstitial nephritisContributory
(SECONDARY)(Duration) 5 yrs. mos. ds.
Cardiac Asthenia

(Signed)

R. C. Mehl M. D.

Sept. 16, 1915 (Address) 1903 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Western Cemetery

DATE OF BURIAL

Sept 16, 1915

20-UNDERTAKER

Josiah Syper 1600 W. North Ave.

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

88243

CERTIFICATE OF DEATH.

151

88243

PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 N. Linwood ave ST.; 6 WARD)

FULL NAME

Residence in Baltimore: No. 103 N. Linwood ave St.; 8 yrs., 8 mos. 8 ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

DATE OF BIRTH,

Sept. 7, 1915
(Month) (Day) (Year)

AGE,

8 yrs., 8 mos., 8 ds. If LESS than 1 day,hrs. or....min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work..... at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE,

(State or Country),

Md Balto

10-NAME OF FATHER,

Jos. Vesceley

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Mary Stepka

13-BIRTHPLACE OF MOTHER

(State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Jos. Vesceley
103 N. Linwood
(Address).....

15-

ROBERT J. BRAUTER

SEP 17 1915

Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 7 1915, to Sept 15 1915,that I saw him alive on Sept 15 1915,and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Emile J. Brown M. D.Sept 16, 1915 (Address) 823 N. Patterson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Common Nat. Cem

DATE OF BURIAL,

Sept. 17, 1915

20-UNDERTAKER

Jos. J. Merr

ADDRESS

1814 E Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *546 W. Conway* ST.; *22* WARD)2-FULL NAME *Katherina Becker*Residence in Baltimore: No. *728 McHenry* St.; *70* yrs., *—* mos., *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*6-DATE OF BIRTH, *Feb. 28th, 1834*

(Month)

(Day)

(Year)

7-AGE, *81* yrs., *6* mos., *19* ds.

If LESS than 1 day,hrs. or....min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work, *House Painter*

(b) General nature of industry, business, or establishment in which employed (or employer).....

8-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *John K. Phil*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Elizabeth Loeffler*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jacob H. Seibert*(Address) *546 W. Conway St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 16th, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 2* 191*5*, to *Sept 16* 191*5*, that I saw her alive on " " " 191*5*, and that death occurred, on the date stated above, at *2:45* m.

The CAUSE OF DEATH* was as follows:

Air embolism of Liver(Duration).....yrs. *3* mos.ds.CONTRIBUTORY *Related to heart* (Secondary)(Duration).....yrs. *2* mos.ds.(Signed) *J. M. L. ...* M. D.*Sept 16, 1915* (Address) *826 31 Carroll St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery*DATE OF BURIAL, *Sept 18, 1915*

20-UNDERTAKER

ADDRESS

Mrs. John H. Seibert, 801 K. Fayette St.

SEP 17 1915

ROBERT BRAUTER

Burial. Permitted. Clerk

Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1615 Miller*ST.: *7*

WARD)

REGISTERED NO. C

2-FULL NAME *Mrs Carrie Glasser*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1615 Miller*St.: *30* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

Unknown.

(Month)

(Day)

(Year)

7-AGE,

49

yrs. mos. ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic
General Family

9-BIRTHPLACE, (State or Country),

VA

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo. Morris*(Address) *919 Rutland Ave*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Sept**15**1915*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *Aug 12* 1915, to *Sept 15* 1915, that I saw him alive on *Sept 15* 1915, and that death occurred, on the date stated above, at *8 P* m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cardiac Dropsy (Duration) yrs. mos. ds.(Signed) *Edward J. Fisher* M. D.*Sept 16* 1915 (Address) *1012 E. Monument St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*National Cemetery**Sept. 17, 1915*

UNDERTAKER

ADDRESS

*Edt. A. Elliott**576 Rogers Ave*

Filed

SEP 17 1915

ROBERT H. RAUTER

Bureau of Health

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *1156 Columbia Ave. 21*)2-FULL NAME *Morie L. Byron*(Residence in Baltimore: No. *1156 Columbia Ave.*)REGISTERED No. C *167*

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *2* yrs., *3* mos *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

May 18th 1913

7-AGE,

*2**3 mos. 27 ds.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

Md. Balto.

10-NAME OF FATHER,

Nicholas Byron

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Maudie Elizabeth Smith

13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elizabeth Smith*(Address) *1156 Columbia Ave.*

15-

Filed.....

191

ROBERT H. BRAUTER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 15th 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....

(Inquest, au-

*Inquest*topsy or inquiry.) and that said deceased came to *her* death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns (Playing with matches) accident

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

Samuel W. M. D.

(Coroner.)

Sept 16, 1915. (Address) 2302 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Mt Olivet Cemetery**Sept 17, 1915*

20-UNDERTAKER

ADDRESS

John Fields 1200 W. Lombard St.

C88217

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88217

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. 1318 S. Light

120
23
ST. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Kate Broaghan

(Residence in Baltimore: No.

1318 S. Light

St. yrs. mos. 41 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

12 - 20, 1854
(Month) (Day) (Year)

7-AGE

60 yrs. 9 mos. 20 ds. or less than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Housewife
Domestic duties9-BIRTHPLACE
(State or country)

Ireland

10-NAME OF FATHER

Wm. Kelly

PARENTS

11-BIRTHPLACE OF FATHER
(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Sarah Jones

13-BIRTHPLACE OF MOTHER
(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. Jones
318 S. Light St.

15

Filed

SEP 17 1915

ROBERT KRAUTH

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 15, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1915, to Sept. 15, 1915, that I saw her alive on Sept. 14, 1915, and that death occurred, on the date stated above, at 8:45 P.M. The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 2 yrs. - mos. - ds.

Contributory (SECONDARY)

Nervous

(Duration) 1 yrs. - mos. - ds.

(Signed) Emil Novak M. D.
Sept 16, 1915 (Address) 268 Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

J. J. Jones

318 S. Light St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and Bldg. No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH.

15-DATE OF DEATH,

16-I HEREBY CERTIFY, That I attended deceased from Sept 15 1915, to Sept 16 1915, that I saw him alive on Sept 16 1915, and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

Sept 16, 1915. (Address) 1900 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

17-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

18-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

SEP 17 1915

ROBERT KRAUTHR,

Burial Permit Clerk

Registrar.

Peter Nicolaus

2046 Eastern

C88249

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88249

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Josephs Hospital* ST. *12* WARD)

REGISTERED NO. C.....

2-FULL NAME

(Residence in Baltimore: No. *1432 Belvidere* St.; yrs. *9* mos. *9* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*Colored*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

Feb. 26, 1900
(Month) (Day) (Year)

7-AGE,

*15 yrs. 5 mos. 19 ds.*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Schoolboy*

9-BIRTHPLACE,

(State or Country),

Maryland Balt.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles R. Sewell*(Address) *1432 Belvidere St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept. 14, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Sept 10* 1915, to *Sept 14* 1915, that I saw him alive on *Sept 14* 1915, and that death occurred, on the date stated above, at *9:15 a.m.*

The CAUSE OF DEATH* was as follows:

Symphoid fever(Duration) yrs. mos. *15* ds.

CONTRIBUTORY (Secondary)

Pneumonia(Duration) yrs. mos. *7* ds.

(Signed)

Ernest W. Rieger, M.D.
Sept 14, 1915 (Address) *St. Josephs Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *4* ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

1432 Belvidere St.

Former or usual residence

1432 Belvidere St.

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

Sept. 17, 1915

20-UNDERTAKER

Geo. W. Holland

ADDRESS

577 Robert St.

Filed

SEP 17 1915

HUBERT KRAUTH,
Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital*)

2-FULL NAME

(Residence in Baltimore: No. *228 W. Biddle*)

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *34* yrs., *1* mos., *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

-DATE OF BIRTH,

(Month)

(Day)

(Year)

-AGE,

If LESS than 1 day, hrs. or min.

-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

SEP 17 1915

ROBERT

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from *Sept. 15, 1915*, to *Sept. 15, 1915*, that I saw him alive on *Sept. 15, 1915*, and that death occurred, on the date stated above, at *1206*.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

CONTRIBUTORY (Secondary)

(Signed) *Frank M. M. M. D.*
Sept. 15, 1915, (Address) *Mary Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *Don't know*Former or usual residence *228 W. Biddle*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88251

C88251

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2214 E. Monument ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2214 E. Monument St.; 39 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-SINGLE, married, MARKED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Sept 17, 1887
(Month) (Day) (Year)

7-AGE, 51 yrs., 4 mos., 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Clerk
(b) General nature of industry, business, or establishment in which employed (or employer), Employer

9-BIRTHPLACE, (State or Country), Anne Arundel Co. Md

10-NAME OF FATHER, George Miller

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Harriett Russell

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia R. Miller(Address) 2214 E. Monument St

SEP 17 1915

Filed..... 191.....

ROBERT J. KRAUTER

Burial Permit Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1915, to Sept 17 1915, that I saw him alive on Sept 16 1915, and that death occurred, on the date stated above, at 4:15 a.m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris
(Duration)..... yrs. 6 mos. ds.

CONTRIBUTORY.....
(Secondary) (Duration)..... yrs. mos. ds.

(Signed) Helmutt Roberts M. D.
Sept 17 1915 (Address) 2129 E. Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Balto Cemetery

20-UNDERTAKER

John B. Spencer

DATE OF BURIAL,

Sept 17, 1915.

ADDRESS

1325 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1626 Lancaster*)

ST.: *2* WARD)

REGISTERED No. C.

2-FULL NAME

Stanislawa Pasinska

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1626 Lancaster*)

St.; yrs., *24* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

— — — — — 1893
(Month) (Day) (Year)

7-AGE,

22 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

Laundress in Laundry
Wise Brothers

9-BIRTHPLACE,

(State or Country),

Russia

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Anna Pawlak

(Address)

1626 Lancaster St

15-

ROBERT KRAUTER

Maria Permalik

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 15, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, autopsy & inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

D.W. Jones M. D.

(Coroner.)

Sept 16

1915. (Address) *316 O'Donnell St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary

Sept 18, 1915

20-UNDERTAKER

ADDRESS

M. F. Sadowski

705 S. Cum

SEP 17 1915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *9* WARD)REGISTERED NO. C *92*2-FULL NAME *Patrick Kelly*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *14 Gaeffer Ave.* St. *68* yrs. *—* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*6-DATE OF BIRTH, *Unknown*

(Month)

(Day)

(Year)

7-AGE, *73*

yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Ship Carpenter*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Ireland*10-NAME OF FATHER, *Mykhar*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo. E. Kelly*(Address) *Hamilton Mc*

SEP 17 1915

ROBERT KRAUTER,
Municipal Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *September 15, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 14* 1915 to *Sept 15* 1915, that I saw him alive on *Sept 15* 1915, and that death occurred, on the date stated above, at *3 P.* m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar(Duration) yrs. mos. *5* ds.CONTRIBUTORY (Secondary) *Myocarditis*(Duration) yrs. mos. *2* ds.(Signed) *G. W. Smith* M. D.*Sept 15, 1915* (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. *1* ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? *German Ave*Former or usual residence *German Ave*19-PLACE OF BURIAL OR REMOVAL, *New Cathedral*DATE OF BURIAL, *Sept 16, 1915*20-UNDERTAKER, *W. G. Schmeisser*ADDRESS, *Remax Park*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2643 Penna Ave* ST: *13* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *2643 Penna Ave*St.: *40* yrs., mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widower*

6-DATE OF BIRTH,

unknown; 1 (Month) (Day) (Year)

7-AGE,

about 68

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Clerk*
(b) General nature of industry, business, or establishment in which employed (or employer). *unknown*

9-BIRTHPLACE, (State or Country),

Md.

10-NAME OF FATHER,

Thomas Riley

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Laura V. Riley*(Address) *2643 Penna Ave*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 16, 191*5* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 13* 191*3*, to *Sept 16* 191*5*, that I saw him alive on *Sept 14* 191*5*, and that death occurred, on the date stated above, at *22* m.

The CAUSE OF DEATH* was as follows:

Paresis(Duration) *2* yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *O. N. Duwall*

M. D.

9/16 191... (Address) *1877 Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Brookside Md

DATE OF BURIAL,

Sept 17, 191*5*

20-UNDERTAKER

H. G. K. M. H. H.

ADDRESS

Thomas North

SEP 17 1915

ROBERT

KRAUTER,

Filed... 191... Serial... Per...
11-1-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *914 Peach Alley* ST.;

WARD)

REGISTERED No. C *23* *150*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James Montgomery Godwin*(Residence in Baltimore: No. *914 Peach Alley* St.;yrs. *4* mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *male*4-COLOR OR RACE *Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word)6-DATE OF BIRTH *Sept. 16*

(Month)

(Day)

(Year)

7-AGE *42*

yrs. mos. ds.

If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE.
(State or Country), *Maryland Baltimore*10-NAME OF FATHER, *James Montgomery Godwin*11-BIRTHPLACE OF FATHER
(State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Clara Hopkin*13-BIRTHPLACE OF MOTHER
(State or Country), *Maryland*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thomas H. Godwin*(Address) *Mercer*

ROBERT KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 16*, 191*5*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept. 16* 191*5*, to *Sept. 16* 191*5*that I saw him alive on *Sept. 16* 191*5*and that death occurred, on the date stated above, at *4:30* m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency
(premature birth, patient)
toram (Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Frank M. M...* M. D.*Sept. 16*, 191*5*. (Address) *Mercer Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Auburn*DATE OF BURIAL, *Sept. 17, 1915*20-UNDERTAKER *L. H. ...*ADDRESS *1814 ...*

SEP 17 1915

1915

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88256

C88253

CERTIFICATE OF DEATH

103

1 PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C

CITY OF BALTIMORE: (No.

St.: 10

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Leonia Roach

(Residence in Baltimore: No.

Little Sisters of the Poor

St.: 2 yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE ☒ MARRIED ☐ WIDOWED ☐ OR DIVORCED *Widow*
(Write the word)

6-DATE OF BIRTH *July 4, 1855*
(Month) (Day) (Year)

7-AGE *60* yrs. *7* mos. *12* ds. or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore*

10-NAME OF FATHER *John Mitchell*
11-BIRTHPLACE OF FATHER (State or country) *Germany*
12-MAIDEN NAME OF MOTHER *Anna Eng*
13-BIRTHPLACE OF MOTHER (State or country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Sister Benedict*

(Address) *Little Sisters of the Poor*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept 16, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *no record*
191 to 191

that I saw her alive on 191

and that death occurred, on the date stated above, at *7 A.* m.

The CAUSE OF DEATH* was as follows:

Gastric
Unknown (Duration) yrs. mos. ds.

Contributory (SECONDARY) *Excessive heat*
E (Duration) yrs. mos. ds.

(Signed) *F. L. Wamer* M. D.
Sept 16, 1915 [Address] *1133 Val Bldg*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *2* yrs. *1* mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

London Park *Sept 17, 1915*

20-UNDERTAKER ADDRESS
H. C. Knudsen *914 Broadway Ave*

SEP 17 1915

HOBERT . KRACHT
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)FULL NAME *Gustavus Evans*Residence in Baltimore: No. *University Hospital* St. *4* yrs. *5* mos. *5* ds.)REGISTERED No. C *88257*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX.

Male

4-COLOR OR RACE,

*White*5-~~SINGLE~~,
MARRIED, *Married*
~~WIDOWED~~
OR ~~DIVORCED~~
(Write the word.)

6-DATE OF BIRTH

*March**3rd*, *1866*

(Month)

(Day)

(Year)

7-AGE,

49

yrs.

6

mos.

14

ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

Sta. Eng. Co.

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Hampton Evans

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Catherine Beard

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Susan Evans

(Address)

Alberton Md.

SEP 17 1915

ROBERT . KRAUTER

Filed....., 191.....

Burial Permit. O. O. R.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*September**17*, *1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 13

1915, to

Sept. 17

1915,

that I saw him alive on *Sept. 16*

1915,

and that death occurred, on the date stated above, at *4:40* m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration).....

yrs.....

mos.....

ds.....

CONTRIBUTORY.....

(Secondary)

(Duration).....

yrs.....

mos.....

ds.....

(Signed)

*Elmer W. H. C. M. D.**9-17-1915*, 1915. (Address)*University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs.....

mos.....

ds.....

In the

State

yrs.....

mos.....

ds.....

Where was disease contracted, if not at place of death?

Former or

usual residence

Alberton - Maryland

19-PLACE OF BURIAL OR REMOVAL,

Alberton Maryland

DATE OF BURIAL,

Sept. 20, 1915

20-UNDERTAKER

Geo. A. Gerbig

ADDRESS

1200 W. Bay

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1303 May St.*)REGISTERED NO. C *5 28*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Lillian A Wright(Residence in Baltimore: No. *1303 May*)

St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX. <i>Female</i>	4-COLOR OR RACE, <i>Colored</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>Single</i>
DATE OF BIRTH, <i>Unknown, 1900</i> (Month) (Day) (Year)		
AGE, <i>15</i> yrs. — mos. — ds. If LESS than 1 day, — hrs. or — min.?		
OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <i>School girl</i>		
BIRTHPLACE, (State or Country), <i>N. Y.</i>		
10-NAME OF FATHER, <i>Major Wright</i>		
11-BIRTHPLACE OF FATHER (State or Country), <i>va</i>		
12-MAIDEN NAME OF MOTHER <i>Mary Williams</i>		
13-BIRTHPLACE OF MOTHER (State or Country), <i>va</i>		

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Williams*(Address) *1303 May St.*

SEP 18 1915

HARRY W. ANDREWS,

Filed....., 191.....
Marial Peralt, Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 14, 1915*
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Aug 28, 1915*, to *Sept 14, 1915*, that I saw him alive on *Sept 12, 1915*, and that death occurred, on the date stated above, at *9 a* m.
The CAUSE OF DEATH* was as follows:*Chronic meningitis, tuberculosis*
Indefinite (Duration) — yrs. — mos. — ds.CONTRIBUTORY *anemia*
(Secondary) *2 weeks* (Duration) — yrs. — mos. — ds.(Signed) *Edward J. Fisher* M. D.
Sept 14, 1915 (Address) *1612 E. Monroe St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Laurel Cem.* DATE OF BURIAL, *Sept 17, 1915*20-UNDERTAKER *Mary J. Locks* ADDRESS *1302 Jefferson*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *George Zepp*(Residence in Baltimore: No. *University Hospital* St.; yrs., mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Sept 11 1915
(Month) (Day) (Year)

7-AGE,

48

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

*Day*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Geo Zepp*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Susan Bellings*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Deceased*

(Address)

SEP 18 1915

HARRY O. A. UNIVERSITY OF MARYLAND

Serial. *Permit. 0191*

Registrar.

20-UNDERTAKER

Commissioner Health

ADDRESS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 15 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 11 1915, to *Sept 15* 1915,that I saw him alive on *Sept 15* 1915,and that death occurred, on the date stated above, at *8:45 P.m.*

The CAUSE OF DEATH* was as follows:

Dysphoid Fever(Duration).....yrs.....mos. *14* ds.CONTRIBUTORY
(Secondary)*Hemorrhage*(Duration).....yrs.....mos. *3* ds.

(Signed).....

Edward Bonella M. D......, 191... (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. *5* ds. In the State.....yrs.....mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

North Branch

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

SEP 19 1915

20-UNDERTAKER

Commissioner Health

FOR ANATOMICAL PURPOSES.

C88260

HEALTH DEPARTMENT—CITY OF BALTIMORE

169

C88260

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *found off Pratt St. Rm #4*)ST. *4*

WARD)

REGISTERED NO. C

FULL NAME

Unknown

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *Unknown*)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

*Colored*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7 (Month) *1* (Day) (Year)

7-AGE,

*about 60*If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *?*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),*?*

PARENTS.

10-NAME OF FATHER,

*?*11-BIRTHPLACE OF FATHER
(State or Country),*?*

12-MAIDEN NAME OF MOTHER

*?*13-BIRTHPLACE OF MOTHER
(State or Country),*?*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Police Records -*

(Address)

15-

Filed

SEP 18 1915

HARRY O. ANDREWS

191. Marital Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 30, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, au-*inquest* and that said deceased came to *his* death (Inquest, au-
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

*Accident - Drowned fell
on railroad off Rm #4 Pratt St*

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Harry O. Andrews* M. D.
(Coroner.)*Sept 15*, 1915. (Address) *18 W. Franklin St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

PUBLIC CEMETERY.

SEP 16 1915

20-UNDERTAKER
Commissioner Health.

ADDRESS

C88261

HEALTH DEPARTMENT—CITY OF BALTIMORE^x

C88261

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Med. Gen. Hospital*
 CITY OF BALTIMORE: (No. *11* ST.; *11* WARD)
 2-FULL NAME *Louise Middleton*
 (Residence in Baltimore: No. *None* St.; yrs., mos., da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Female</i>	4-COLOR OR RACE <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Single</i> (Write the word.)
6-DATE OF BIRTH, <i>1</i> (Month) (Day) (Year)		
7-AGE <i>15</i> yrs., mos., da.		8-IF LESS than 1 day, hrs. or min.?
9-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer).....		
10-BIRTHPLACE, (State or Country), <i>Va.</i>		
10-NAME OF FATHER, <i>Do not know</i>		
11-BIRTHPLACE OF FATHER (State or Country), " " "		
12-MAIDEN NAME OF MOTHER " " "		
13-BIRTHPLACE OF MOTHER (State or Country), " " "		

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*T. L. Wright*
 (Address).....*Med. Gen. Hospital*

5-*SEP 18 1915*
 HARRY O. ANDREWS, PUBLIC HEALTH REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH
Sept 12, 191*5*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 30* 191*5*, to *Sept 12* 191*5*, that I saw her alive on *Sept 12* 191*5*, and that death occurred, on the date stated above, at *11:45 A.M.*

The CAUSE OF DEATH* was as follows:
Cerebro-spinal meningitis
(Epidemic form)
 (Duration).....*7*..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....
 (Duration)..... yrs..... mos..... ds.

(Signed).....*Frank S. Shipley M.D.*
Sept 12 191*5* (Address).....*Med. Gen. Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....*2 1/2*..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? *?*

Former or usual residence.....*Ellicott City, Md.*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

PUBLIC CEMETERY

SEP 16 1915

20-UNDERTAKER

ADDRESS

Commercial Health.

W. V. 882

C88262

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

* 28

C88262

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. *10*)

WARD)

2-FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1B.)

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX <i>male</i>	4-COLOR OR RACE <i>Black</i>	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>Single</i>
6-DATE OF BIRTH <i>January 1st 1888</i> (Month) (Day) (Year)		
7-AGE <i>27</i> yrs. <i>8</i> mos. <i>2</i> ds. or min.? If LESS than 1 day, hrs.		
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <i>Farmer Laborer</i>		
9-BIRTHPLACE (State or country) <i>Harford Co., Md.</i>		
PARENTS	10-NAME OF FATHER <i>Loos Harris</i>	
	11-BIRTHPLACE OF FATHER (State or country) <i>Maryland</i>	
	12-MAIDEN NAME OF MOTHER <i>Susannah Brown</i>	
	13-BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John H. ...
Address: *Md. Penitentiary*

15-

HARRY O. ANDERSON

Filed

191

Marial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

September 3, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *DEC. 13, 1914*, to, *September 3, 1915*, that I saw him alive on *September 2, 1915*, and that death occurred, on the date stated above, at *5:20 A.m.*

The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion

Contributory (SECONDARY) *Pubesary Tuberculosis*
(Duration) yrs. *21* mos. *21* ds.
(Signed) *William F. Schwartz* M.D.
Sept-3, 1915 (Address) *Md. Penitentiary*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *4* yrs. *2* mos. *16* ds. State *...* yrs. *...* mos. *...* ds.

Where was disease contracted, If not at place of death?

Former or usual residence *Stuartsville, Harford Co., Md.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*PUBLIC CEMETERY**SEP 16 1915*

20-UNDERTAKER

ADDRESS

Comptroller of Health

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88263

C88263

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

The Hermann Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1127 N Mount

ST.:

15

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Ida Carroll

Residence in Baltimore: No.

1437 Carroll Alley

St.: 1 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED, Married
WIDOWER,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

40 or about

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Carroll Co. Md.

10-NAME OF FATHER,

George Bowman

11-BIRTHPLACE OF FATHER

(State or Country),

Carroll Co. Md.

12-MAIDEN NAME OF MOTHER

Bowman

13-BIRTHPLACE OF MOTHER

(State or Country),

Carroll Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

6th

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 24th 1915, to Sept 6th 1915,that I saw her alive on Sept 5th 1915,

and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Typhoid Fever

(Duration)..... yrs. mos. ds.

(Signed)..... J. A. Evans M. D.

Sept 6th 1915. (Address) 101 N. Carey St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 13 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Unknown

Former or usual residence

1437 Carroll Alley

19-PLACE OF BURIAL OR REMOVAL,

PUBLIC CEMETERY.

DATE OF BURIAL,

SEP 18 1915

20-UNDERTAKER

General Health

ADDRESS

SEP 18 1915

HARRY O. ANDREWS,

Registrar.

C88261 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *Falls near Pratt* St. *4* WARD) REGISTERED No. C
2-FULL NAME *Not Known*
(Residence in Baltimore: No. *Not Known* St.; yrs., *Not Known* mos. *Not Known* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, *Not Known* WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, *Not Known*, 1 (Month) (Day) (Year)
7-AGE, *45* yrs. *1* mos. *1* ds. IF LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Not Known*
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country). *Not Known*
10-NAME OF FATHER, *Not Known*
11-BIRTHPLACE OF FATHER (State or Country), *Not Known*
12-MAIDEN NAME OF MOTHER, *Not Known*
13-BIRTHPLACE OF MOTHER (State or Country), *Not Known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

SEP 18 1915

HARRY O. ANDREWS,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 7, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to *his* death today or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Accidental Drowning

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... *D. W. Jones* M. D. (Coroner.)

Sept. 13., 1915. (Address) *3116 Wisconsin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

SEP 16 1915

20-UNDERTAKER, *Commissioner Health.*

ADDRESS

C88265

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88265

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *1711 Lancaster*)

ST.

WARD)

REGISTERED NO. C

FULL NAME

Not known

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1711 Lancaster*)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED, *Not known*
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Not known, *1*
(Month) (Day) (Year)

7-AGE,

70 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

General

9-BIRTHPLACE,

(State or Country),

Not known

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER (State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

SEP 18 1915

Filed....., 191.....

HARRY O. ANDREWS
Registrar.

PUBLIC CEMETERY.

20-UNDERTAKER

Commiss. for Health.

16-DATE OF DEATH,

Sept 9, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry*
(Inquest, autopsy, or inquiry.)thereon and from the evidence obtained by said *inquest*
(Inquest, au-*inquiry* and that said deceased came to *death*
(topsy, or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....*D. W. Jones*.....M. D.
(Coroner.)*Sept. 9, 1915* (Address).....*1316 W. Journal St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,
SEP 18 1915

ADDRESS

C88266

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph Hospital*ST.: *23* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1824 Light St*

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)

6-DATE OF BIRTH, *Not Known* 18*90*
(Month) (Day) (Year)

7-AGE, *25* yrs., mos., ds. If LESS than 1 day, hrs. or min.?

OCCUPATION:
(a) Trade, profession, or particular kind of work. *furniture maker*
(b) General nature of industry, business, or establishment in which employed (or employer).....

8-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *Not Known*

11-BIRTHPLACE OF FATHER (State or Country), *Not Known*

12-MAIDEN NAME OF MOTHER, *Not Known*

13-BIRTHPLACE OF MOTHER (State or Country), *Not Known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

5-

HARRY O. ANDREWS,
191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 12*, 191*5*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 21* 191*5*, to *Sept 12* 191*5*, that I saw him alive on *Sept 11* 191*5*, and that death occurred, on the date stated above, at *12:15 a.m.*

The CAUSE OF DEATH* was as follows:

Typhoid fever
(Duration)..... yrs., mos., ds.

CONTRIBUTORY, *Broncho Pneumonia*
(Secondary)

(Duration)..... yrs., mos., ds.
(Signed) *Ernest H. Ryan, M.D.*
Sept 12, 191*5*. (Address) *St Joseph Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the life yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1824 Light St*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

PUBLIC CEMETERY.

SEP 16 1915

20-UNDERTAKER
Commissioner Health.

ADDRESS

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88267

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *4*)

ST.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)

2-FULL NAME

Goldie Johnson

(Residence in Baltimore: No. *St. Paul St.*)

St.; *1* yrs. *1* mos. *9* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

colored

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

single

6-DATE OF BIRTH

July

25, 1914

7-AGE

1

9

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

Ind.

10-NAME OF FATHER

Ruffert Johnson

11-BIRTHPLACE OF FATHER
(State or country)

Ind.

12-MAIDEN NAME OF MOTHER

Mamie Johnson

13-BIRTHPLACE OF MOTHER
(State or country)

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

HARRY O. ANDREWS,

SEP 18 1915

Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September

1915

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 25, 1915* to, *Sept 2, 1915*, that I saw her alive on *May 2, 1915*, and that death occurred, on the date stated above, at *8* p.m.

The CAUSE OF DEATH* was as follows:

*Alimentary decomposition
Chronic severe malnutrition*

(Duration) yrs *3* mos. ds.

Contributory
(SECONDARY)

Edgar F. Friedmanwald
Sept 3, 1915 [Address] *1616 Lincoln Ave.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs *3* mos *8* ds. State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL
PUBLIC CEMETERY.

DATE OF BURIAL

SEP 16 1915

20-UNDERTAKER
Commissioner Health.

ADDRESS

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88268

CERTIFICATE OF DEATH.

152 C88268

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 0 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*
 4-COLOR OR RACE. *Black*
 5-SINGLE, *Single*
 MARRIED, WIDOWED, OR DIVORCED.
 (Write the word.)
 6-DATE OF BIRTH, *9-15-1915*
 (Month) (Day) (Year)

7-AGE,

0 yrs., 0 mos., 0 ds.

If LESS than 1 day,
9 hrs. or 0 min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Name*
*Name*9-BIRTHPLACE,
(State or Country),*Md.*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

5-

Filed

SEP 18 1915 HARRY O. ANDREWS,
Serial Form 10-1-15 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

9-15-1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
9-15-1915, to *9-15-1915*,
that I saw her alive on *9-15-1915*,
and that death occurred, on the date stated above, at *9 P.M.*

The CAUSE OF DEATH* was as follows:

Congenital Cerebral Palsy..... (Duration)..... yrs..... mos..... ds.
CONTRIBUTORY.....
(Secondary).......... (Duration)..... yrs..... mos..... ds.
(Signed) *P. L. Rush* M. D.
9-15-1915, (Address) *University Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

COLLEGE OF P. & S.

SEP 17 1915

20-UNDERTAKER

Commissioner Health.

ADDRESS

Per. Wm E. WOODALL.

buried

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88269

CERTIFICATE OF DEATH.

PLACE OF DEATH
 CITY OF BALTIMORE: (No. 238 Pine ST. 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME Anné Collins
 (Residence in Baltimore: No. 238 Pine St. St.; 0 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX. <u>Female</u>	4-COLOR OR RACE, <u>Black.</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, <u>9</u> <u>15</u> , 19 <u>15</u> (Month) (Day) (Year)		
7-AGE, <u>0</u> yrs., <u>0</u> mos., <u>0</u> ds. If LESS than 1 day, <u>9</u> hrs. or <u>0</u> min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work... <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)... <u>None</u>		
9-BIRTHPLACE, (State or Country), <u>Ind.</u>		
10-NAME OF FATHER, <u>Richard Collins</u>		
11-BIRTHPLACE OF FATHER (State or Country), <u>Bacto. Md.</u>		
12-MAIDEN NAME OF MOTHER <u>Edna Bowles.</u>		
13-BIRTHPLACE OF MOTHER (State or Country), <u>Greenland Va.</u>		

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

SEP 18 1915

HARRY O. ANDREWS,

Filed..... 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, <u>9</u> - <u>15</u> , 19 <u>15</u> (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I attended deceased from <u>9-15</u> , 19 <u>15</u> , to <u>9-15</u> , 19 <u>15</u> ; that I saw her alive on <u>9-15</u> , 19 <u>15</u> , and that death occurred, on the date stated above, at <u>3:00</u> p.m. The CAUSE OF DEATH* was as follows: <u>Congenital atelectasis</u> (Duration) <u>0</u> yrs., <u>0</u> mos., <u>0</u> ds. CONTRIBUTORY (Secondary) <u>Mitral regurgitation</u> (Duration) <u>0</u> yrs., <u>0</u> mos., <u>0</u> ds. (Signed) <u>L. Rush</u> M. D. <u>9-15</u> , 19 <u>15</u> (Address) <u>University Hospital</u>

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

COLLEGE OF B & S SEP 17 1915

20-UNDERTAKER ADDRESS

Commissioner Health.

Breasted.

C88270

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88270

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1305-Webb)

ST. 10

WARD

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Ella Francisco

(Residence in Baltimore: No. 1305-Webb)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

45

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,
(State or Country),

Va

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country),

Va

12-MAIDEN NAME OF MOTHER

Va

13-BIRTHPLACE OF MOTHER
(State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP 18 1915

191

HARRY O. ANDERSON
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 11, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest,
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

Inquest, and that said deceased came to death
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH was as follows:

Natural Causes
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) P. J. Russell M. D.
(Coroner.)

Sept 11, 1915 (Address) 423 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

PUBLIC CEMETERY.

DATE OF BURIAL,

SEP 16 1915

20-UNDERTAKER

Commissioner Health,

ADDRESS

Per. WM. E. WOODAL

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Black 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Jan. 18, 1874 (Month) (Day) (Year)

7-AGE, 41 yrs. 7 mos. 27 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Housework. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Va.

10-NAME OF FATHER, Howard Lewis

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Rachel Dorrett

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. Phelps

(Address) Johns Hopkins Hsp.

15-ROBERT KRAUTER

Filed SEP 18 1915 191. Burial Parole Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 15, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept. 12 1915 to Sept. 15 1915, that I saw her alive on Sept. 15 1915, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Peritonitis (Duration) ... yrs. ... mos. ... ds.

(Signed) Lawrence Wharton, M. D. Sept. 15, 1915 (Address) Johns Hopkins Hsp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 523 W. Hoffman St.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Mt. Auburn Sept. 18, 1915

20-UNDERTAKER, ADDRESS, L. H. Brown & Son 108 W. Montg.

C88272

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88272

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 110 Warner St.)

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Long Robinson(Residence in Baltimore: No. 110 Warner St.)St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE Black 5-SINGLE, MARRIED widow, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH June, 1820
(Month) (Day) (Year)

7-AGE 70 yrs. 5 mos. ds. or less than 1 day, hrs. min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Md.

10-NAME OF FATHER Mr. Brown
11-BIRTHPLACE OF FATHER (State or country) unknown
12-MAIDEN NAME OF MOTHER unknown
13-BIRTHPLACE OF MOTHER (State or country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Brown
(Address) 506 Leadenhall

15. ROBERT . KRAUTER,Filed SEP 18 1915 Funeral Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept, 17, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1915, to, Sept 17, 1915, that I saw her alive on Sept 18, 1915, and that death occurred, on the date stated above, at 2 m. The CAUSE OF DEATH* was as follows:

Leukemia

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) M. D. Smith M. D.(Address) 506 Leadenhall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Burial Case

DATE OF BURIAL

Sept 19, 1915

20-UNDERTAKER

Am. Th. Chase & Son

ADDRESS

400 Mosher

Hattie Lee
HEALTH DEPARTMENT—CITY OF BALTIMORE

1
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* St. *11* WARD)FULL NAME *Hattie Lee*(Residence in Baltimore: No. *914 Jordan Alley* St. *1* yrs. *1* mos. *1* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *Col.*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *unknown* 1

(Month)

(Day)

(Year)

7-AGE, *19* yrs. *1* mos. *1* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Cook*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward Lee*(Address) *914 Jordan Alley*

15-

ROBERT J. KRAUTER

Filed *SEP 18 1915*Burial Permit No. *101*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *Sept 17, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 21, 1915* to *Sept 17, 1915*, that I saw *her* alive on *Sept 17, 1915*, and that death occurred, on the date stated above, at *8:17 p.m.*

The CAUSE OF DEATH* was as follows:

Septicemia(Duration) *27* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

(Duration) *27* yrs. *1* mos. *1* ds.(Signed) *Frank M. D.**Sept 17, 1915* (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *18* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.Where was disease contracted, if not at place of death? *914 Jordan Alley*Former or usual residence *914 Jordan Alley*19-PLACE OF BURIAL OR REMOVAL *Jewell*DATE OF BURIAL *Sept 20, 1915*20-UNDERTAKER *E. B. Hark*ADDRESS *115 E. North St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. 1432 Presstman ST.; 15 WARD) REGISTERED NO. C
2. FULL NAME Ellen Waters
(Residence in Baltimore: No. 1432 Presstman St.; 15 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX Female 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
(Write the word.)
6. DATE OF BIRTH Unknown 1860
(Month) (Day) (Year)
7. AGE 5-5 yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?
8. OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Cabrest Co. Md
10. NAME OF FATHER John P. Rhoads
11. BIRTHPLACE OF FATHER (State or Country) Cabrest Co. Md
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (State or Country) Unknown

4. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Waters
(Address) 1432 Presstman

5. SEP 18 1915 ROBERT E. RAUTER
Filed 18 1915 BURIAL PERMIT CLARK
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 16, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9 1915, to Sept 16 1915, that I saw her alive on Sept 16 1915, and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) yrs. mos. ds. 7

CONTRIBUTORY
(Secondary)

(Signed) R. P. Rhoads M. D.
9/17, 1915 (Address) 117 N. Calver

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Auburn Sept. 18, 1915

20. UNDERTAKER

ADDRESS

James H. Davis 303 Presstman

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH *St. Joseph's Hospital* REGISTERED NO. *39*
 CITY OF BALTIMORE: (No. *Caroline & Hoffman St.* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 FULL NAME *Joseph Guss*
 Residence in Baltimore: No. *235 Chapel* St.; *57* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single* (Write the word.)
 2-DATE OF BIRTH, *Not Known*, 18*58*
 (Month) (Day) (Year)

3-AGE, *57* yrs., mos. ds. IF LESS than 1 day, hrs. or min.?

4-OCCUPATION:
 (a) Trade, profession, or particular kind of work *Taylor*
 (b) General nature of industry, business, or establishment in which employed (or employer)

5-BIRTHPLACE, (State or Country), *Balto*

10-NAME OF FATHER, *Perclus Gross*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *Sibila Holzman*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Gross*
 (Address) *235 Chapel St*

15-SEP 18 1915 ROBERT KRAUTER, Registrar.

16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *September 18, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug. 28* 191*5*, to *Sept 18* 191*5*, that I saw him alive on *Sept 17* 191*5*, and that death occurred, on the date stated above, at *8:30 P.M.*

The CAUSE OF DEATH* was as follows:
Carcinoma of salivary glands
Secondary metastasis of lungs
 (Duration) *3* yrs., mos. ds.

CONTRIBUTORY *Hypertension*
 (Secondary) (Duration) *2* yrs., mos. ds.

(Signed) *E. W. T. Bishop* M. D.
Sept 18, 1915 (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *21* ds. In the State *57* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *235 Chapel St.*

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer* DATE OF BURIAL, *Sept 20, 1915*

20-UNDERTAKER *Arndell Lippel & Son* ADDRESS *37 So Ann St.*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *2000 Ramsay*)ST. *20*

WARD)

2-FULL NAME *Fena Paulman*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *2000 Ramsay*)St. *25* yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs., min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 6, 1915, to *Sept. 17*, 1915,that I saw her alive on *Sept. 17*, 1915,and that death occurred, on the date stated above, at *8:45 p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *5* yrs. — mos. — ds.

Contributory (SECONDARY)

(Duration) *5* yrs. — mos. — ds.(Signed) *Robert J. Green* M.D.*Sept. 18*, 1915. [Address] *120 1/2 Risquith*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. — mos. — ds. In the State, yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

18-

SEP 18 1915

ROBERT J. KRAUTER,

Municipal Permit Clerk

REGISTRAR

*London Park**Sept. 20*, 1915*William Cook**5026 North*

HEALTH DEPARTMENT—CITY OF BALTIMORE •

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 Bloombury ST. 24 WARD) 91FULL NAME Louis J. McDonough(Residence in Baltimore: No. 117 Bloombury St.; yrs. Life mos. Life ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX.

male

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

DATE OF BIRTH,

Mar 13, 1913
(Month) (Day) (Year)

AGE,

2 yrs. 6 mos. 3 ds. If LESS than 1 day, ... hrs. or ... min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

BIRTHPLACE, (State or Country),

MD, Balt.

10-NAME OF FATHER

Thomas McDonough

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

Margaret Anderson

13-BIRTHPLACE OF MOTHER (State or Country),

MD,

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. McDonough(Address) 117 Bloombury St.

5-

SEP 18 1916

ROBERT

KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 16, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from Sept 19, 1915 to Sept 16, 1915, that I saw him alive on Sept 16, 1915, and that death occurred, on the date stated above, at 12:30 pm.
The CAUSE OF DEATH* was as follows:Pneumonia

CONTRIBUTORY (Secondary)

Convulsions
(Signed) R. Campbell M. D.
Sept 16, 1915 (Address) 1644 Haver St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cedar Hill

UNDERTAKER

E + 13 Harle

DATE OF BURIAL

Sept 18, 1915

ADDRESS

115 E. West St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3724 Falls Road 13 ST. 13 WARD)

2. FULL NAME

(Residence in Baltimore: No. 3724 Falls Road.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 65 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX

Male

4. COLOR OF RACE

White5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)Widowed

6. DATE OF BIRTH

Dec. 31, 1839
(Month) (Day) (Year)

7. AGE

75 yrs., 8 mos., 17 ds.
If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Paper Hanger.9. BIRTHPLACE.
(State or Country).Connecticut

10. NAME OF FATHER

Wm. L. Wheeler11. BIRTHPLACE OF FATHER
(State or Country).Conn.

12. MAIDEN NAME OF MOTHER

Mary Hallan13. BIRTHPLACE OF MOTHER
(State or Country).Conn.

4. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James L. Wheeler(Address) 3724 Falls Road

SEP 18 1915

ROBERT

KRAUTER,

Regist. Permitt. (City & County) Registrar.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 17, 1915
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1915, to Sept 17 1915, that I saw him alive on Sept 17 1915, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Chronic (Interstitial)Pneumonia(Duration) 2 yrs., 8 mos., 17 ds.CONTRIBUTORY (Secondary) Cancer of Prostate(Duration) 6 yrs., 6 mos., 17 ds.(Signed) A. J. Kelly M. D.Sept 7, 1915. (Address) 3849 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Mary's (Hamden) Sept 19, 1915.

20. UNDERTAKER

Horace Bungee Box 3031 Falls Rd.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *8*)

2-FULL NAME

(Residence in Baltimore: No. *8*)

Little Sisters of the Poor

ST. *10* WARD

REGISTERED NO. C. *91*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Mary Ann Ryan

Little Sisters of the Poor

St. *5* yrs. *7* mos. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Maryland

Daniel Ryan

Unknown

Mary Brown

Unknown

Sister Benedict

Little Sisters of the Poor

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-

I HEREBY CERTIFY That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

2 weeks

Contributory (SECONDARY)

(Signed)

Sept 18

H. Warner

[Address]

1183 Valley

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *5* yrs. *4* mos. *15* ds. State *MD*

Where was disease contracted, if not at place of death?

Former or usual residence

Little Sisters of the Poor

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Chester

Sept 21

John J. Baker

1183 Valley

SEP 18 1915

ROBERT KRAUTER,
Municipal Permit Clerk
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

088280

088280

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

CITY OF BALTIMORE: (No. 2007 N (Charles

2-FULL NAME Harry E. Gross

(Residence in Baltimore: No. 2007 N (Charles

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Oct. 29, 1874

(Month)

(Day)

(Year)

7-AGE,

40

yrs., 10

mos.,

da.

If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Carpenter

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER,

Geo. H. Gross

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Martha B. Denton

13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harry E. Gross

(Address)

2007 N. Charles St.

SEP 18 1915

HUBERT

KRAUTER,

Municipal Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 16, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1915, to Sept 16, 1915, that I saw him alive on Sept 16, 1915, and that death occurred, on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)

4

yrs.

mos.

da.

CONTRIBUTORY (Secondary)

(Duration)

Low Immunity

yrs.

mos.

da.

(Signed)

Wm. H. Pearce

(Duration)

yrs.

mos.

da.

Sept 17, 1915

(Address)

2103 N. Charles St.

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

da.

In the

State

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

20-UNDERTAKER

Address

DATE OF BURIAL,

Address

Linden Park Cem.

Sept 19, 1915

Wm. E. Fuller

221 N. Broadway

C88281

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88281

PLACE OF DEATH

Hahnemann Ren Hosp.

REGISTERED No. C

CITY OF BALTIMORE (No. 1122 N. Mount

ST. 13 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Virginia Corbin

(Residence in Baltimore: No. 3357 Falls Road

St. 7 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

Mar

4

1874

(Month)

(Day)

(Year)

7-AGE

41

yrs.

6

mos.

12

ds.

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE

(State or country)

Balto Co, Md.

10-NAME OF FATHER

George Sears

11-BIRTHPLACE OF FATHER

(State or country)

Unknown

12-MAIDEN NAME OF MOTHER

Roseanna Corbin

13-BIRTHPLACE OF MOTHER

(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-SEP 18 1915

ROBERT . KRAUTER

Filed

1915

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept

16

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

June

1915

to

Sept 16

1915

that I saw her alive on

Sept 16

1915

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis (General)

(Duration)

yrs.

mos.

2

ds

Contributory (SECONDARY)

Operation for Gall Stones

(Duration)

yrs.

mos.

ds.

(Signed)

Geo W. W. Hall

M. D.

Sept 16, 1915

(Address)

2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

2

ds.

In the

State

7

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Home

Former or

usual residence

3357 Falls Road

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cockeysville, Md.

Sept. 19, 1915

20-UNDERTAKER

ADDRESS

Horace Burger

363 Falls Rd

Inf of Labalia + Arthur Crowther
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 830 Woodward St. 21 WARD)

2-FULL NAME (Infant) Crowther

(Residence in Baltimore: No. 830 Woodward

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, Sept 16, 1915 (Month) (Day) (Year)

7-AGE, 2 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Bacto

10-NAME OF FATHER, Arthur Crowther 11-BIRTHPLACE OF FATHER (State or Country), England 12-MAIDEN NAME OF MOTHER, Labalia Christopher 13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur B Crowther

(Address) 830 Woodward St. 21

15- SEP 18 1915 ROBERT KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Atelectasis (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) J. S. Jeffers, M. D. (Address) 213 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lenox Park City

DATE OF BURIAL, Sept 18 1915

20-UNDERTAKER, Geo Lembeck

ADDRESS 647 N. ...

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Aged Home 111 Cisquith* ST.; *5* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Moses Chaim Falkman(Residence in Baltimore: No. *111 Cisquith*St.; *14* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widower*

6-DATE OF BIRTH,

1 (Month) *2* (Day) *1852* (Year)

7-AGE,

63 yrs. *—* mos. *—* ds.If LESS than 1 day, *—* hrs. or *—* min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Tailor

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louis Goldman*(Address) *111 Cisquith St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. *18*, *1915*.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May* *1915*, to *Sept. 17* *1915*, that I saw h *in* alive on *Sept. 17* *1915*, and that death occurred, on the date stated above, at *4:00* m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
chronic interstitial nephritis(Duration) *2* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

Myocarditis
(Duration) *4* yrs. *—* mos. *—* ds.(Signed) *D. A. M. Johnson* M. D.*Sept. 15*, *1915* (Address) *1420 E. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs. *4* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.Where was disease contracted, if not at place of death? *—*Former or usual residence *2*

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Mt Carmel

DATE OF BURIAL,

Sept. 19, *1915*.

20-UNDERTAKER

J. L. Johnson & Co.

ADDRESS

1107 E. Baltimore

15-

SEP 19 1915 ROBERT KRAUTER
Burial Permit Clerk
Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *228 S. Epeth* ST. *3* WARD)

2-FULL NAME

(Residence in Baltimore: No. *228 S. Epeth* St. *17* yrs., *—* mos., *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-STATUS,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Married

6-DATE OF BIRTH

Unknown, *1*.....
(Month) (Day) (Year)

7-AGE,

80 yrs., *—* mos., *—* ds.IF LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 18, 191*5*.....
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Aug 12 191*5* to *Sept 17* 191*5*,
that I saw him alive on *Sept 18* th 191*5*,
and that death occurred, on the date stated above, at *5a.* m.

The CAUSE OF DEATH* was as follows:

Cholecystitis (Possibly carcinoma of gall bladder and liver)
(Cholelithiasis)
..... (Duration)..... yrs. *2* mos. ds.CONTRIBUTORY *Cardiac weakness*
(Secondary)..... (Duration)..... yrs. mos. *12* ds.(Signed) *Herbert Krauth* *Slide* M. D.*Sept 18*, 191*5* (Address) *1523 E. Baltimore St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

15-

Filed

SEP 19 1915

HERBERT KRAUTH

Municipal Health Officer

Registrar.

20-UNDERTAKER

ADDRESS

C88285

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 C88285
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 836 E. Pratt)

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 836 E. Pratt)St.: 1 yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

white

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

single

6-DATE OF BIRTH

Sept 15, 1914
(Month) (Day) (Year)

7-AGE

1 yrs. 1 mos. 1 ds. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE
(State or country)

Balt Md

PARENTS

10-NAME OF FATHER

Hyman Grossblatt

11-BIRTHPLACE OF FATHER
(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Esther Tartes

13-BIRTHPLACE OF MOTHER
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

SEP 19 1915

ROBERT A. BRAUTER,

Morial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 17, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 16, 1915, to, Sept 17, 1915.

that I saw him alive on Sept 17, 1915.

and that death occurred, on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Intoxication

(Duration) yrs. mos. 7 ds.

Contributory
(SECONDARY)

Pneumonia

(Duration) yrs. mos. ds.

(Signed)

M. B. Leven

M. D.

Sept 17, 1915

(Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 2 ds. State 1 yrs. mos. ds.

Where was disease contracted,

If not at place of death?

836 E. Pratt

Former or

usual residence

at home

19-PLACE OF BURIAL OR REMOVAL

Hebrew Mt Carmel

DATE OF BURIAL

9/19, 1915

20-UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Pratt

Barney Gardner
 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *John Hopkins Hospital* 7
 CITY OF BALTIMORE: (No. *7* ST.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME *Barney Gardner*
 (Residence in Baltimore: No. *John Hopkins Hospital* St.; yrs. mos. *3* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widower*
 6-DATE OF BIRTH *Jan. 19th* 1852
 (Month) (Day) (Year)
 7-AGE, *65* yrs. mos. da. If LESS than 1 day, hrs. or min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Woodwork*
 (b) General nature of industry, business, or establishment in which employed (or employer). *Cabinet maker*
 9-BIRTHPLACE, (State or Country). *North Carolina*
 10-NAME OF FATHER. *Wm. Gardner*
 11-BIRTHPLACE OF FATHER (State or Country). *North Carolina*
 12-MAIDEN NAME OF MOTHER *Cynthia Betts*
 13-BIRTHPLACE OF MOTHER (State or Country). *North Carolina*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. B. Ross*(Address) *John Hopkins Hospital*

15-SEP 19 1915

ROBERT K. KRAUTER

Baltimore Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *Sept. 17th* 1915.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept. 14th* 1915, to *Sept. 17th* 1915, that I saw him alive on *Sept. 17th* 1915, and that death occurred, on the date stated above, at *3:55 P. M.*

The CAUSE OF DEATH* was as follows:

Sarcoma of neck

(Duration) *5* yrs. mos. da.
 CONTRIBUTORY *Surgical Shock following operation*
 (Secondary) (Duration) *0* yrs. mos. da.
 (Signed) *Harvey J. Messer* M. D.
Sept. 17, 1915 (Address) *John Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *3* da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence *Spring Hope - North Carolina*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Mount Airy N.C.**Sept. 17, 1915*

20-UNDERTAKER

ADDRESS

*Albert C. Fuller**221 N. Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1754 Carswell* ST.; *9* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out Nos. 18.)

FULL NAME *Elizabeth A. Farrell*(Residence in Baltimore: No. *1754 Carswell*St.; *60* yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)

6-DATE OF BIRTH, _____, *1874*
(Month) (Day) (Year)

7-AGE, *71* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *House wife*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *New York, N. Y.*

10-NAME OF FATHER, *James Fitzpatrick*

11-BIRTHPLACE OF FATHER (State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER *Bridget Fitzpatrick*

13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Farrell*(Address) *1754 Carswell St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 16*, 1915.
August (Month) *3* (Day) *1915* (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug. 3* 1913, to *Sept. 16*, 1915, that I saw her alive on *Sept. 16*, 1915, and that death occurred, on the date stated above, at *10:5 P. m.*

The CAUSE OF DEATH* was as follows:

Paralysis of left side(Duration) *2* yrs. *1* mos. *13* ds.CONTRIBUTORY... *Excessive heat*
(Secondary)(Duration) *5* yrs. *5* mos. *5* ds.(Signed) *Edwin B. Tenby, M. D.**Sept. 15*, 1915. (Address) *1223 N. Caroline*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Catholic Home Bldg.**Sept. 20*, 1915.

20-UNDERTAKER

ADDRESS

Wm J. Schaeffer & Son, 100 N. Front St.

SEP 19 1915

ROBERT J. KRATT

BALTIMORE PERMIT CLERK

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88283

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital*)

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1A.)

2-FULL NAME

(Residence in Baltimore: No. *Mercy Hospital*)St.; *0* yrs., *0* mos., *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

Not Known, 1884
(Month) (Day) (Year)

7-AGE,

31 yrs., *0* mos., *0* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Laborn*
*City*9-BIRTHPLACE,
(State or Country)*Italy*

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Vincent Sabatino*(Address) *114 Albemarle*

15-

Filed

SEP 19 1915

ROBERT KRAUTHOR

MAY 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 18, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Sept 9, 1915*, to *Sept 18, 1915*, that I saw him alive on *Sept 18, 1915*, and that death occurred, on the date stated above, at *525* m.

The CAUSE OF DEATH* was as follows:

Infected
Sever
(Duration) *0* yrs., *2* mos., *4* ds.CONTRIBUTORY
(Secondary)*Sever Pneumonia*
(Duration) *3* yrs., *3* mos., *3* ds.
(Signed) *Frank M. Mason* M. D.
Sept 18, 1915 (Address) *Mercy Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *0* yrs., *0* mos., *10* ds. In the State *0* yrs., *0* mos., *0* ds.Where was disease contracted, if not at place of death? *Don't know*Former or usual residence *Union Bridge, Md.*

19-PLACE OF BURIAL OR REMOVAL,

H. Vincents

DATE OF BURIAL,

Sept. 21, 1915

20-UNDERTAKER,

William Fialkowski

ADDRESS,

1618 Eastern Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 S. Bond

2-FULL NAME

(Residence in Baltimore: No. 312 S. BondMary NagratowskaST. 3

WARD)

REGISTERED NO. C 91 C88289

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 14.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

July

(Month)

16

(Day)

1915

(Year)

7-AGE,

yrs. 2mos. 2ds. 2If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)None9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

Wladyslaw Nagratowski11-BIRTHPLACE OF FATHER
(State or Country),Russian Poland

12-MAIDEN NAME OF MOTHER

Kaz Matorowski13-BIRTHPLACE OF MOTHER
(State or Country),Russian Poland14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. Nagratowski(Address) 312 S. Bond

15-

SEP 19 1915

ROBERT J. KRAUTER,
Municipal Health Officer
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 18

(Month)

18

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from
Sept 18 1915, to Sept 18 1915,
that I saw h^e alive on Sept 18 1915,
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:Bronch. PneumoniaCONTRIBUTORY
(Secondary)

(Duration)

Endic Pulsesmos. 2ds. 1(Signed) William J. Kramet

(Duration)

Sept 19, 1915(Address) 2005 Oaklandmos. 1ds. 1*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

of death

yrs. 1mos. 1ds. 1

In the

State

yrs. 1mos. 1ds. 1Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

UNDERTAKER

William J. Kramet

DATE OF BURIAL,

Sept 20, 1915

ADDRESS

1618 Eastern Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *205 S Gilman* ST.; *19* WARD)2-FULL NAME *Margaret Kalvelage*(Residence in Baltimore: No. *205 S Gilman* St.; *Life* yrs., *Life* mos. *Life* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Jan *6*, 18*48*
(Month) (Day) (Year)

7-AGE,

67 yrs. *8* mos. *11* da. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Balto. Md*10-NAME OF FATHER, *John Smith*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jas H. Kalvelage*(Address) *1302 Hillen St*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 17*, 19*15*
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *May 17* 1915, to *Sept 17* 1915, that I saw her alive on *Sept 16* 1915, and that death occurred, on the date stated above, at *1:05 P.* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) *4* yrs. *4* mos. *—* ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs. *—* mos. *—* ds.(Signed) *W. D. M. D.**Sept 18*, 1915. (Address) *108 N. Baltimore Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Oliver*DATE OF BURIAL, *Sept 20*, 1915.

20-UNDERTAKER

Robt. T. Turner

ADDRESS

Broadway & Olive

15-

SEP 19 1915

ROBERT KRAUTER

Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

852 S. Bond

ST. 1 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

James Korityki

Residence in Baltimore: No.

852 S. Bond

St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

April

26

1915

(Month)

(Day)

(Year)

7-AGE,

4

mos.

23

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

None

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

PARENTS.

10-NAME OF FATHER,

Wojciech Korityki

11-BIRTHPLACE OF FATHER (State or Country),

Austria Poland.

12-MAIDEN NAME OF MOTHER

Julia Ruck

13-BIRTHPLACE OF MOTHER (State or Country),

Austria Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Julia Korityki

(Address)

852 S. Bond St

15-

Filed

SEP 19 1915

ROBERT J. KRAUTH

Baltimore Health Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept.

18

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 15 1915, to Sept. 18 1915,

that I saw him alive on Sept 18 1915,

and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) John St. Rehberger M. D.

Sept 18 1915 (Address) 1709 Albemarle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

Sept 20, 1915

20-UNDERTAKER

M. J. Sadowski

ADDRESS

705 S. Ann St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1926 Alice Anne* ST. *2* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

2-FULL NAME *Melvin Dominick*(Residence in Baltimore: No. *1926 Alice Anne* St.; yrs., *8* mos. *20* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the words.)6-DATE OF BIRTH, *Dec 30, 1914*
(Month) (Day) (Year)7-AGE, *8 mos. 20 ds.* If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Joseph Dominick*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Sophia Kustel*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-SEP 19 1915 HOBKRT KRAJINS

Filed..... 101..... REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 19, 1915*
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Sept 16, 1915* to *Sept 19, 1915*, that I saw him alive on *Sept 18, 1915* and that death occurred, on the date stated above, at *4:30* m.

The CAUSE OF DEATH* was as follows:

Measles(Duration)..... yrs. mos. *5* ds.CONTRIBUTORY (Secondary) *Bronchitis Pneumonia*(Duration)..... yrs. mos. *2* ds.(Signed) *W. J. D.**Sept. 19, 1915* (Address) *2008 S. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *H. Stanislaus* DATE OF BURIAL, *Sept. 20, 1915*20-UNDERTAKER *M. F. Sadowski* ADDRESS *405 S. ...*

88293

HEALTH DEPARTMENT—CITY OF BALTIMORE

88293

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *2004 Lincoln Court* St.: *6* WARD)2-FULL NAME *Joseph Chambers*(Residence in Baltimore: No. *2004 Lincoln Court* St.: yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)6-DATE OF BIRTH, *Unknown Sept 18th 1911* (Month) (Day) (Year)7-AGE, *42* yrs. mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Laborer* (b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Ind*10-NAME OF FATHER, *Joseph Chambers*11-BIRTHPLACE OF FATHER (State or Country), *Ind*12-MAIDEN NAME OF MOTHER, *Rebecca Horsey*13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Chambers*(Address) *2004 Lincoln Court*

15- SEP 20 1915 HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 18th 1915* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Chas. F. Russell* M. D. (Coroner.)*Sept 18th 1915* (Address) *4423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Asbury* DATE OF BURIAL, *Sept 20 1915*20-UNDERTAKER *John W. Henderson* ADDRESS *317 Carroll St*

C88294

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88294

CERTIFICATE OF DEATH.

155
REGISTERED No. C.

PLACE OF DEATH

CITY OF BALTIMORE (No. 155)

2-FULL NAME

(Residence in Baltimore: No. 2529 West Balto

Franklin Square Hospital
Lucille D. Crevenstein
2529 West Balto

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

April

5

(Day)

1894

(Year)

7-AGE,

21 yrs.

5 mos.

13 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,
(State or Country),

Balto city

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER
(State or Country),

Balto city

Crevenstein Rue

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP 20 1915

HARRY O. ANDREWS,

Filed

191

Marital Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

18th

1915

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Mercury Poisoning

Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Saml. H. Hines, M. D.

Sept 19th 1915 (Address) 2302 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs. mos. ds. In the

21 yrs. mos. ds.

Where was disease contracted, if not at place of death?

2529 W. Balto St.

Former or usual residence 2529 W. Balto St.

19-PLACE OF BURIAL OR REMOVAL,

Goudon Park

DATE OF BURIAL,

Sept 20 1915

20-UNDERTAKER,

Wm. Quon

ADDRESS

507 E. NO. Ave

088295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

088295

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1006 Necessity Al.* - *5* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1006 Necessity Al.* St.; *7* yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Unknown, 1878
(Month) (Day) (Year)

7-AGE,

37 yrs., mos., ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Washing & Ironing

9-BIRTHPLACE, (State or Country),

Ind.

10-NAME OF FATHER,

Don't Know

11-BIRTHPLACE OF FATHER (State or Country),

Don't Know

12-MAIDEN NAME OF MOTHER

Don't Know

13-BIRTHPLACE OF MOTHER (State or Country),

Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. Tinson*(Address) *1006 Necessity Al.*

SEP 20 1915

Filed....., 191

HARRY O. ANDREWS,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 18th, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Sept 10th* 1915, to *Sept 18th* 1915,that I saw her alive on *17th* 1915,and that death occurred, on the date stated above, at *5:40 P.* m.

The CAUSE OF DEATH* was as follows:

Coma

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY *Chronic nephritis*
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *Jacob L. Winner* M. D.*9-18-15*, 1915 (Address) *308 B. way*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Asbury C**Sept 20th*, 1915

20-UNDERTAKER

ADDRESS

Wm. G. Jackson *1409 Mulliken St*

C88296

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

103 C88296
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,

Female

White

Single

6-DATE OF BIRTH

June

27, 1873

7-AGE

42

yrs.

2

mos.

21

ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Seamstress

9-BIRTHPLACE

(State or country)

Baltimore City

10-NAME OF FATHER

Kunrich W. Edelen

PARENTS

11-BIRTHPLACE OF FATHER

(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Emma A. Bruner

13-BIRTHPLACE OF MOTHER

(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Edwin Edelen

(Address)

248 N. Monroe St.

15.

SEP 20 1915

HARRY O. ANDERSON,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept

17

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 6th, 1915, to, Sept. 17th, 1915.that I saw her alive on Sept. 17th, 1915.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Catarrhal Gastritis

(Duration) yrs. 2 mos. 11 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Robt. J. Murray M. D.

Sept. 20, 1915 (Address) 510 N. Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Linden Park Cem.

Sept 20, 1915

20-UNDERTAKER

ADDRESS

Joseph B. Cook

603 W. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1016 N. Bond*ST.; *7* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary L. Kirsch*(Residence in Baltimore: No. *1016 N. Bond*St.; *75* yrs., *6* mos., *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

*March**3rd**1940*

(Month)

(Day)

(Year)

7-AGE.

*75**6*yrs. *15* mos. *15* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*none*9-BIRTHPLACE,
(State or Country).*Balto. Md.*

PARENTS.

10-NAME OF FATHER.

*Henry Schuster*11-BIRTHPLACE OF FATHER
(State or Country).*Germany*

12-MAIDEN NAME OF MOTHER

*not known*13-BIRTHPLACE OF MOTHER
(State or Country).*not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. Louis Kirsch*(Address) *1016 N. Bond St.*

15-

Filed

SEP 20 1915

191

HARRY O. ANDERSON

NOTARIAL PUBLIC

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 18th 1915

(Month)

(Day)

(Year)

17-

HEREBY CERTIFY, That I attended deceased from

Sept 3rd 1915

to

Sept 18th 1915

19

that I saw him alive on *Sept 18th 1915*and that death occurred, on the date stated above, at *8:00* p. m.

The CAUSE OF DEATH* was as follows:

Central Anaplexia(Duration) *15* yrs. *15* mos. *15* ds.CONTRIBUTORY
(Secondary)*Cerebral*(Duration) *14* yrs. *14* mos. *14* ds.(Signature) *Dr. J. H. Jones* M. D.(Address) *15th St. N. W.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *15* yrs. *15* mos. *15* ds. In the State *15* yrs. *15* mos. *15* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Greenmount Cemetery**Sept 22, 1915*

20-UNDERTAKER

ADDRESS

*Henry Hoecke**1301 E. Eager*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph's Hospital* ST. *7* WARD)

2-FULL NAME *Geo F Buchta*

(Residence in Baltimore: No. *936 N Bond*

St. yrs., 2 mos. / 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*

4-COLOR OR RACE, *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)

6-DATE OF BIRTH, *July 3rd, 1891*

7-AGE, *24* yrs., *2* mos., *15* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Leather Worker*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) *Balto Md*

10-NAME OF FATHER, *Geo F Buchta*

11-BIRTHPLACE OF FATHER (State or Country), *Md*

12-MAIDEN NAME OF MOTHER *Hattie White*

13-BIRTHPLACE OF MOTHER (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr Geo F Buchta*

(Address) *936 N Bond St*

15-

SEP 20 1915

Filed

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 18th, 1915*

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Pulmonary Tuberculosis*

(Signed) *Charles F. Russell* M. D. (Coroner.)
Sept 18th, 1915 (Address) *423 N Bond St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery*

DATE OF BURIAL, *Sept 22, 1915*

20-UNDERTAKER *Henry Wood*

ADDRESS *1301 E 34th St*

88299

HEALTH DEPARTMENT—CITY OF BALTIMORE

30 88299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *1908 N. Patterson Park Ave.* St. *19* yrs., *11* mos. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH

October 12, 1895
(Month) (Day) (Year)

7-AGE,

19 yrs., 11 mos., 7 ds.

IF LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

Nurse

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

George Gnapp

11-BIRTHPLACE

OF FATHER
(State or Country),*Baltimore Md.*

12-MAIDEN NAME

OF MOTHER

Not known

13-BIRTHPLACE

OF MOTHER
(State or Country),*Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Oliver D. Jones*(Address) *1908 N. Patterson Park Ave. Balt. Md.*

15-

SEP 20 1915

HARRY O. ANDERSON

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

September 19, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

*Sept 17, 1915, to Sept 19, 1915,*that I saw her alive on *Sept 19, 1915,*and that death occurred, on the date stated above, at *8 A.M.*

The CAUSE OF DEATH* was as follows:

*Tubercular Meningitis**About 4 yrs., 4 mos., 1 ds.*

CONTRIBUTORY

(Secondary)

*Myocarditis**(Duration) 1 ds.*(Signed) *P. V. Lynch* M. D.*Sept 19, 1915* (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs. *10* mos. *3* ds. In the *19* yrs. *10* mos. *3* ds. StateWhere was disease contracted, if not at place of death? *1908 N. Patterson Park Ave.*Former or usual residence *1908 N. Patterson Park Ave.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mary's Cemetery (Baltimore) *Sept 22, 1915*

20-UNDERTAKER

ADDRESS

Henry Horch & Son *1301 E. Engle St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3517 Ash*)

2-FULL NAME

(Residence in Baltimore: No. *3517 Ash*)

REGISTERED NO. C

ST.: *13* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *1* yrs., *10* mos., *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Single*

6-DATE OF BIRTH,

Sept 8, 1915
(Month) (Day) (Year)

7-AGE,

1 yrs., *10* mos., *10* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*none*9-BIRTHPLACE,
(State or Country),*Balt City*

PARENTS.

10-NAME OF FATHER,

*Philip Boulder*11-BIRTHPLACE OF FATHER
(State or Country),*Balt City*

12-MAIDEN NAME OF MOTHER

*Viola Roney*13-BIRTHPLACE OF MOTHER
(State or Country),*Balt City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Philip Boulder*(Address) *3517 Ash*

15-

SEP 20 1915

Filed 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 18, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Sept 16* 1915, to *Sept 18* 1915,that I saw h *et* alive on *Sept 17* 1915, and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH* was as follows:

Marasmus(Duration) *6* yrs., *6* mos., *10* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yr., *6* mos., *10* ds.(Signed) *C. F. Jones*

M. D.

9/18, 1915 (Address) *3517 Ash*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Marys Hospital *Sept 20 1915*

20-UNDERTAKER

ADDRESS

Chenoweth Son *Chestnut*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Wardman General Hospital* ST.; *9* WARD)

REGISTERED NO. C

FULL NAME *Mrs. Mary L. Pullman*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *658 Cokesbury Ave* St.; *30* yrs., *10* mos., *10* da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. *Female* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH. *November 8, 1883*
(Month) (Day) (Year)

7-AGE. *31 yrs., 10 mos., 10 da.* If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). *Cincinnati Ohio*

10-NAME OF FATHER. *J. J. MacCullar*

11-BIRTHPLACE OF FATHER (State or Country). *Massachusetts*

12-MAIDEN NAME OF MOTHER *Mrs. Fannie Thayer*

13-BIRTHPLACE OF MOTHER (State or Country). *Massachusetts*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *F. H. Pullman*

(Address) *658 Cokesbury Ave*

15-

SEP 20 1915

Filed 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *September 18, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept. 12 - 1915*, to *Sept. 18 - 1915*, that I saw her alive on *Sept. 18 - 1915*, and that death occurred, on the date stated above, at *2:45* m.

The CAUSE OF DEATH* was as follows:

Postoperative Shock and Collapse following Amputation of Cervix - Degeneration of the ovaries and Venereal Infection. (Duration) ... yrs. ... mos. ... *4* da.

CONTRIBUTORY *Dyspareunia* (Secondary)

(Duration) ... yrs. ... mos. ... *4* da.

(Signed) *S. J. Schilling* M. D.

Sept. 18, 1915. (Address) *Wd. General Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. *6* da. In the *30* yrs. ... mos. ... *10* da.

Where was disease contracted, if not at place of death?

Former or usual residence *658 Cokesbury Ave*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

London Park Cemetery *Sept. 21, 1915*

20-UNDERTAKER ADDRESS

George Schilling, Sons *1126 E. M. ...*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland Hospital 3* ST. *3* WARD)

2-FULL NAME

Residence in Baltimore: No. *11415 Eastern Ave*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Sept 30, 1858

(Month)

(Day)

(Year)

7-AGE,

56

yrs.

11

mos.

23

da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Bank Clerk*9-BIRTHPLACE,
(State or Country),*Pa.*

10-NAME OF FATHER,

*William Miller*11-BIRTHPLACE OF FATHER
(State or Country),*Pa.*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Margaret Miller

(Address)

230 E. Church St.

15-

SEP. 20 1915

HARRY O. ANDREWS,

Corial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 20, 1915

(Month)

(Day)

(Year)

1- I HEREBY CERTIFY, That I attended deceased from *Sept. 18, 1915* to *Sept. 20, 1915*, that I saw him alive on *Sept. 20, 1915*, and that death occurred, on the date stated above, at *5:45 a.m.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) *Don't know*CONTRIBUTORY
(Secondary)(Duration) *Don't know*(Signed) *Frank M. Mason* M. D.17-20-1915 (Address) *Maryland Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *2* yrs. *2* mos. *30* da. In the State *30* da.Where was disease contracted, if not at place of death? *Don't know*Former or usual residence *11415 Eastern Ave*

19-PLACE OF BURIAL OR REMOVAL.

Western Cemetery

DATE OF BURIAL.

Sept 22, 1915

20-UNDERTAKER.

John J. Cowan & Son

ADDRESS

901 Holler

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88303

CERTIFICATE OF DEATH.

138

C88303

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

University Hosp

ST.;

WARD)

REGISTERED NO. C

2-FULL NAME

Elizabeth Heil

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

220 Barney St

St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Married

6-DATE OF BIRTH.

Oct. 1, 1876
(Month) (Day) (Year)

7-AGE.

38 yrs. 11 mos. 18 ds.

If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,

(State or Country).

Knoxville Tenn.

10-NAME OF FATHER,

Frank Corsett

11-BIRTHPLACE OF FATHER

(State or Country), Knoxville Tenn.

12-MAIDEN NAME OF MOTHER

Mary E. Rolth

13-BIRTHPLACE OF MOTHER

(State or Country), Eastern shore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Henry Heil

(Address)

220 E. Barney

15-

Filed.....

1915. Sept. 20. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept. 19, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Sept. 17, 1915, to Sept. 19, 1915, that I saw her alive on Sept. 19, 1915, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Eclampsia
Puerperal
(Duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

Uremia
(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) P. S. Rush M. D.
9-19, 1915 (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the 30 yrs. mos. ds.

Where was disease contracted, if not at place of death?

220 E. Barney

Former or usual residence

220 E. Barney

19-PLACE OF BURIAL OR REMOVAL,

London Pk Cem

DATE OF BURIAL,

Sept. 22, 1915.

20-UNDERTAKER

J. F. McCall

ADDRESS

39 E. Fort.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf't Asy.* ST.; *14* WARD)2-FULL NAME *Mary Doyle*(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.;

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs. *5* mos. *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) *Single*

6-DATE OF BIRTH,

*March**24th**1915*

7-AGE,

yrs. *5* mos. *24* ds.

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-SEP 20 1915

HARRY U. ANDERSON

Filed..... 1915.....

1915.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH,

*Sept**17th**1915*

17- I HEREBY CERTIFY, That I attended deceased from *Sept 1st* 1915, to *Sept 17th* 1915, that I saw him alive on *Sept 17th* 1915, and that death occurred, on the date stated above, at *11⁰⁰ a.m.*

The CAUSE OF DEATH* was as follows:

Malnutrition and Malassimilation

(Duration) yrs. *2* mos. *4* ds.

CONTRIBUTORY (Secondary)

(Signed) *John S. Farley* M. D.
Sept 17, 1915. (Address) *1323 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *5* mos. *24* ds. In the State yrs. *5* mos. *24* ds.Where was disease contracted, if not at place of death? *St. Vincent's Inf't Asylum*Former or usual residence *St. Vincent's Inf't Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*Cathedral Cem**Sept 20, 1915*

20-UNDERTAKER

ADDRESS

Marion F. Anderson
616 Lafayette Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88305

CERTIFICATE OF DEATH.

104 C88305
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.: *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Robert Simpson(Residence in Baltimore: No. *St. Vincent's Inf. Asylum* St.: yrs. mos. *20* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) *Single*

6-DATE OF BIRTH.

August 29, 1915
(Month) (Day) (Year)

7-AGE.

yrs. mos. *22* ds.

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE.
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 20, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 18* 1915, to *Sept 20* 1915, that I saw him alive on *Sept 20* 1915, and that death occurred, on the date stated above, at *9 A.M.*

The CAUSE OF DEATH* was as follows:

Gastro-enteritis(Duration) yrs. mos. *2* ds.CONTRIBUTORY
(Secondary)(Duration) yrs. mos. *2* ds.(Signed) *John D. Lamb* M. D.*Sept 20, 1915* (Address) *1323 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *1* 20 ds. In the State yrs. mos. *20* ds.Where was disease contracted, if not at place of death? *St. Vincent's Inf. Asylum*Former or usual residence *St. Vincent's Inf. Asylum*

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Cathedral been *Sept. 20, 1915*

20-UNDERTAKER

ADDRESS

Martin Lakey & Sons 806 Lafayette Ave

15-

SEP 20 1915

101 HARRY O. ANDERSON

Registrar.

C88306

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88306

CERTIFICATE OF DEATH.

151
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2000 Eager

ST. 7

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Florence Anna Schmidt

(Residence in Baltimore: No. 2000 Eager St.

St.; yrs. mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Single

6-DATE OF BIRTH

Sept. 13, 1915

(Month)

(Day)

(Year)

7-AGE,

— yrs. — mos. 6 ds.

If LESS than 1 day.

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

None

9-BIRTHPLACE,
(State or Country),

Baltimore, Maryland

10-NAME OF FATHER,

Jerome Schmidt

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Sophia Koenigsman

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jerome Schmidt

(Address)

2000 Eager St.

15-

SEP 20 1915

Filed

191

HARRY O. ANDREWS

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 19, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from
Sept 13 1915, to Sept 19 1915,
that I saw her alive on Sept 18 1915,
and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds. 6

(Duration) yrs. mos. ds. 6

(Signed)

Emil Kovach, M. D.

Sept 20 1915 (Address) 823 N. Patterson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Hill

DATE OF BURIAL,

20-UNDERTAKER

W. J. Schaff

ADDRESS

8 S. Front

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

104
REGISTERED NO. C

CITY OF BALTIMORE: (No. *522 N. Elmer* ST. *7* WARD)

2-FULL NAME *Julia M. Ruth*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RW out No. 18.)

(Residence in Baltimore: No. *522 N. Elmer* St.; *7* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*

4-COLOR OR RACE *White*

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) *Single*

6-DATE OF BIRTH *March 12* 1915

(Month)

(Day)

(Year)

7-AGE *6* yrs. *7* mos. *7* ds. or *1* day, *7* hrs. *7* min.?

If LESS than

1 day, *7* hrs. *7* min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country) *md*

PARENTS

10-NAME OF FATHER *Louis W. Ruth*

11-BIRTHPLACE OF FATHER
(State or country) *md*

12-MAIDEN NAME OF MOTHER *Mary A. Schlenker*

13-BIRTHPLACE OF MOTHER
(State or country) *md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Louis W. Ruth*

(Address) *522 N. Elmer St*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *September 19* 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 10*, 1915, to, *Sept 19*, 1915,

that I saw him alive on *11*, 1915,

and that death occurred, on the date stated above, at *10:30 P.* m.

The CAUSE OF DEATH* was as follows:

Gastroenteritis

(Duration)

yrs

2

mos.

7

ds.

Contributory
(SECONDARY)

(Duration)

yrs

mos.

ds.

(Signed) *J. O. Schenck* M. D.

Sept 19, 1915 [Address] *2400 B. St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *St. Alphonsus Cemetery*

DATE OF BURIAL *Sept 21* 1915

20-UNDERTAKER *Christian Miller*

ADDRESS *2334 Jefferson St*

REGISTRAR

18-

HARRY O. ANDREWS,

SEP 20 1915

1915

C88308

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88308

CERTIFICATE OF DEATH.

170
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Kohunamun Gun* St.; *12* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James A. Smyser*(Residence in Baltimore: No. *1913 St Paul* St.; *25* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, *male*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*6-DATE OF BIRTH, *Feb 4th 1849*

(Month)

(Day)

(Year)

7-AGE, *66* yrs. *7* mos. *15* ds.

IF LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Iron Works*(b) General nature of industry, business, or establishment in which employed (or employer), *prop*9-BIRTHPLACE, (State or Country), *York Pa.*10-NAME OF FATHER, *Edward J. Smyser*11-BIRTHPLACE OF FATHER (State or Country), *York Pa.*12-MAIDEN NAME OF MOTHER *Jane Dowdel*13-BIRTHPLACE OF MOTHER (State or Country), *York Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. B. Spahr*(Address) *York Pa.*

SEP 20 1915

HARRY O. ANDREWS,

Filed..... 1915

Baltimore, Md.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *September 19th 1915*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 1st* 1915, to *Sep 17* 1915, that I saw him alive on *Sep 18* 1915, and that death occurred, on the date stated above, at *6:45 A.M.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) *4* yrs. mos. ds.CONTRIBUTORY (Secondary) *Tuberculosis*(Duration) *3* yrs. mos. ds.(Signed) *Willie V. Mark* M. D.*Sep 19th* 1915. (Address) *S. 33 Hamilton Square*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *7* yrs. mos. ds. In the *25* yrs. mos. ds. StateWhere was disease contracted, if not at place of death? *1913 St. Paul St*Former or usual residence *1913 St Paul St*19-PLACE OF BURIAL OR REMOVAL, *York Pa.*DATE OF BURIAL, *Sept. 21st 1915*20-UNDERTAKER *Henry W. Jenkins & Sons 60 Orchard St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1804 A Chapel ST.; 12 WARD) REGISTERED NO. C
2-FULL NAME John Canton Jr
(Residence in Baltimore: No. 1804 A Chapel St. ST.; 12 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)
6-DATE OF BIRTH Sept 18 1852
(Month) (Day) (Year)

7-AGE 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) General

9-BIRTHPLACE, (State or Country), Balta Md.

10-NAME OF FATHER Jno. Canton
11-BIRTHPLACE OF FATHER (State or Country) Ireland
12-MAIDEN NAME OF MOTHER Mary Burke
13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Gessler
(Address) 1206 W. Franklin

15-FILED SEP 20 1915 HARRY O. ANDERSON, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 18, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1915, to Sept 18 1915, that I saw him alive on Sept 16 1915, and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) 6 yrs. mos. ds.

(Signed) Jacob F. Fisher M. D.
Sept 20, 1915. (Address) 1926 E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. mos. ds. In the State 12 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Peter DATE OF BURIAL, Sept 21, 1915.

20-UNDERTAKER John A. Moran ADDRESS Bank & Ann St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1115 W. Cross*

ST.:

REGISTERED NO. C

WARD *21*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Julia Cross*(Residence in Baltimore: No. *1115 W. Cross*St. *—* yrs. *—* mos. *3* ds)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *Sept 17, 1915*

(Month)

(Day)

(Year)

7-AGE, *4* yrs. *3* mos. *3* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Bald Md*10-NAME OF FATHER, *Maynard Cross*11-BIRTHPLACE OF FATHER (State or Country), *Bald Md*12-MAIDEN NAME OF MOTHER, *Chlorine Schen*13-BIRTHPLACE OF MOTHER (State or Country), *Bald Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Maynard Cross*(Address) *1115 W. Cross*

15-

SEP 20 1915

HARRY O. ANDREWS

Filed

191. *1115 W. Cross*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 20, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 17, 1915*, to *Sept 20, 1915*, that I saw her alive on *Sept 19, 1915*, and that death occurred, on the date stated above, at *10 A.M.*

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) *—* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.(Signed) *H. O. Andrews* M. D.1915 (Address) *517 South*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park Cem*DATE OF BURIAL, *Sept 20, 1915*

20-UNDERTAKER

ADDRESS

for goerdens c. son 217 Blacast

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH
 CITY OF BALTIMORE: (No. *1115 W Cross*) ST.; *21* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 *FULL NAME *Eugene C. Cunn*
 Residence in Baltimore: No. *1115 W Cross* St.; *21* yrs., *2* mos., *2* ds)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
 6-DATE OF BIRTH, *Sept 7*, 1915 (Month) (Day) (Year)
 7-AGE, *2* yrs., *2* mos., *2* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, *Maynard Cunn*
 11-BIRTHPLACE OF FATHER (State or Country), *Bald Md*
 12-MAIDEN NAME OF MOTHER, *Catherine Schen*
 13-BIRTHPLACE OF MOTHER (State or Country), *Bald Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Maynard Cunn*
 (Address) *1115 W Cross St.*

15-SEP 20 1915 HARRY O. ANDREWS, Registrar.
 Filed..... 191..

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 19*, 1915 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Sept 17* 1915, to *Sept 19* 1915, that I saw h *alive* on *Sept 19* 1915, and that death occurred, on the date stated above, at *5 P* m. The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) *8* yrs., *8* mos., *8* ds.

CONTRIBUTORY (Secondary)

(Duration) *8* yrs., *8* mos., *8* ds.

(Signed) *Edmund Smith* M. D.

Sept 20, 1915 (Address) *517 S. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park Cem* DATE OF BURIAL, *Sept 20*, 1915.

20-UNDERTAKER, *Jos Joordense Son* ADDRESS *217 S. 1st St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3310 Old Frederick Rd* ST. *20* WARD)2-FULL NAME *Martha Katz*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *3310 Old Frederick Rd* St. *50* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Widowed*

6-DATE OF BIRTH.

August 18, 1837
(Month) (Day) (Year)

7-AGE,

78

yrs. mos. ds.

If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).*House work*9-BIRTHPLACE,
(State or Country),*Germany*10-NAME OF
FATHER,*Unknown*

PARENTS.

11-BIRTHPLACE
OF FATHER
(State or Country),*Germany*12-MAIDEN NAME
OF MOTHER*Unknown*13-BIRTHPLACE
OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ernest Engelhaupt*(Address) *3310 Old Frederick Rd*

15-

SEP 20 1915

HARRY O. ARNDT

Filed

1915

Marial Parmit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 18, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Aug 1 1915, to *Sept 17* 1915,
that I saw her alive on *Sept 17* 1915,
and that death occurred, on the date stated above, at *4 a* m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis(Duration) *Unknown* yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Wm. H. L. Lott* M. D.
Sept 18, 1915 (Address) *Portico, Indiana**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*Landon Park Cem.**Sept 20, 1915*

20-UNDERTAKER

Charles W. Lill

ADDRESS

3109 Frederick Ave.

C88313

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88313

CERTIFICATE OF DEATH

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *1213 N. Bradford* ST. *8* WARD)

2-FULL NAME

John Behlke

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1213 N. Bradford* St. yrs. *1 1/2* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*Married*

6-DATE OF BIRTH

Sept

(Month)

12

(Day)

1848

(Year)

7-AGE

67

yrs.

mos.

ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Farming*
*Retired*9-BIRTHPLACE
(State or country)*Germany*

10-NAME OF FATHER

*Unknown*11-BIRTHPLACE OF FATHER
(State or country)*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or country)*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John L. Behlke

(Address)

Maryo R.C. Ma

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September

(Month)

18

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 6, 1915, to, *Sept 18*, 1915,that I saw him alive on *Sept 18*, 1915,and that death occurred, on the date stated above, at *11:10* p.m.

The CAUSE OF DEATH* was as follows:

Chronic? Interstitial Nephritis
& Gastritis

(Duration)

yrs. *6*

mos.

12

ds.

Contributory
(SECONDARY)

(Duration)

yrs. *6*

mos.

ds.

(Signed),

R.P. Carman

M. D.

Sept 19, 1915 [Address] *1701 N. Caroline*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Campbell's Cemetery**Sept 21*

1915

20-UNDERTAKER

ADDRESS

*Chamney - Sub**369 West St*

15-SEP 20 1915

HARRY O. ANDREWS

Marial Permit Clerk

REGISTRAR

Filed

191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital*)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *Johns Hopkins Hospital*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

St.; yrs., mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

Aug 2, 1914
(Month) (Day) (Year)

7-AGE,

13 mos. 17 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Gayle B. Lown*(Address) *Grand Avenue N.Y.*

15-

Filed

SEP 20 1915

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 19, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Sept 18, 1915* to *Sept 19, 1915*, that I saw her alive on *Sept 19, 1915*, and that death occurred, on the date stated above, at *3:00 p.m.*
The CAUSE OF DEATH* was as follows:*Pyelocystitis*(Duration) yrs. mos. *16* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *G. F. Power* M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *6* ds. StateWhere was disease contracted, if not at place of death? *Johns Hopkins Hospital*Former or usual residence *111 Lincoln Washington D.C.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

C88315

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

C88315

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

915 N. Vincent

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Irene Frances Holland

(Residence in Baltimore: No.

915 N. Vincent

St.; yrs. 9 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Caucasian

5-SINGLE, *Infant*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Dec.

13

1914

(Month)

(Day)

(Year)

7-AGE,

9 mos. 6 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

Bolto. City

10-NAME OF FATHER,

John Holland

11-BIRTHPLACE OF FATHER
(State or Country),

Prince George's Co. Md.

12-MAIDEN NAME OF MOTHER

Bessie Clifford

13-BIRTHPLACE OF MOTHER
(State or Country),

Front Royal Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

John Holland

(Address).....

915 N. Vincent St.

15-

SEP 20 1915

HARRY O. ANDREWS,

Filed

191

Marital Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept.

19

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 17 - 1915

to Sept. 19 - 1915

that I saw her alive on Sept. 19 - 1915,
and that death occurred, on the date stated above, at 6:10 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration)..... yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... Chas. L. McFarthy, M. D.

Sept. 20, 1915. (Address) 906 N. Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn Co

Sept. 20, 1915

20-UNDERTAKER

ADDRESS

Hilkey & Brown

306 N. Mount St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88316

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *820 N. Fayette*ST.: *18* WARD)

REGISTERED NO. C

2-FULL NAME

Frank Michael Callier

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *820 N. Fayette St.*St.: *43* yrs. *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE

*Married**Widowed**Or divorced*

(Write the word.)

6-DATE OF BIRTH.

*March**26**1835*

(Month)

(Day)

(Year)

7-AGE

*80**5**19*

ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country)

Baltimore, Md.

10-NAME OF FATHER.

unknown

11-BIRTHPLACE OF FATHER.

(State or Country)

unknown

12-MAIDEN NAME OF MOTHER.

unknown

13-BIRTHPLACE OF MOTHER.

(State or Country)

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

True. Muriella J. Collier

(Informant)

820 N. Fayette St.

(Address)

15-

SEP 20 1915

Filed

191

ROBERT KRAUTER

Baltimore Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*Sept.**19**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May

191

to

Sept 19

1915

that I saw him alive on *July 28* 1915,and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH* was as follows:

Organic heart lesion
initial resuscitation

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Inflammation of old age and
intemperate use of tobacco

(Duration)

yrs.

mos.

ds.

(Signed)

Leonard C. Beach

M. D.

Sept. 20, 1915. (Address) *1 E. 21 St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Boston Park Cemetery**Sept 21, 1915*

20-UNDERTAKER

ADDRESS.

*George J. Smith**820 N. Fayette St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1207 S Decker Ave

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Rosie Duritrow

(Residence in Baltimore: No.

1207 S Decker Ave

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED
(Write the word.)

Single

6-DATE OF BIRTH,

Aug

21

1914

(Month)

(Day)

(Year)

7-AGE,

1

yrs.

mos.

30

ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

Michael Duritrow

11-BIRTHPLACE OF FATHER
(State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Teresa Karmazyn

13-BIRTHPLACE OF MOTHER
(State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Michael Duritrow

(Address).

1207 S Decker Ave

15-

SEP 20 1915

Filed

191

ROBERT KRAUTER
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

20

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from
Sept 16 1915, to Sept 20 1915,
that I saw her alive on Sept 18 1915,
and that death occurred, on the date stated above, at 8:40 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)

Chronic Gastroenteritis

(Duration) yrs. mos. 4 ds.

(Signed) H. B. O'Leary M. D.

Sept 20 1915. (Address) 3035 E. Carroll

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Stanislaus

Sept 21 1915

20-UNDERTAKER

ADDRESS

Stephen J. Ziackowski 1019 S. Kenwood Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *1024 Lanewood* St.; *6* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Helen E. Reierlein*(Residence in Baltimore: No. *1024 Lanewood* St.; *3* yrs., *3* mos., *6* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OF RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH *June 3* 191*5*

(Month)

(Day)

(Year)

7-AGE, *3* yrs., *3* mos., *16* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) *Baltimore*10-NAME OF FATHER *James G. Reierlein*11-BIRTHPLACE OF FATHER (State or Country) *A. A. Conrad*12-MAIDEN NAME OF MOTHER *Mary E. Elmer*13-BIRTHPLACE OF MOTHER (State or Country) *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James G. Reierlein*(Address) *1024 Lanewood*

15-SEP 21 1915

Filed

191

HARRY O. ANDREWS

Marital Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *Sept 19* 191*5*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *Sept 20* 191*5*, to *Sept 19* 191*5*,that I saw her alive on *Sept 19* 191*5*,and that death occurred, on the date stated above, at *6* m.

The CAUSE OF DEATH* was as follows:

Acute Marasmus(Duration) *1* yrs., *3* mos., *16* ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs., *3* mos., *16* ds.(Signed) *Harry O. Andrews* M. D.(Address) *1419 E. 14th St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *3* yrs., *3* mos., *16* ds. In the State *3* yrs., *3* mos., *16* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Sept 21* 191*5*20-UNDERTAKER *Robert J. Turner*ADDRESS *1419 E. 14th St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

OF BALTIMORE: (No. *1708 Baker*)FULL NAME *William Thomas Ray*(Residence in Baltimore: No. *1708 Baker St.*)

REGISTERED NO. C

ST.: *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *72* yrs., — mos. *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

Jan. 24, 1843
(Month) (Day) (Year)

7-AGE,

72 yrs., *7* mos., *27* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Painter General*

9-BIRTHPLACE, (State or Country).

Richmond Va

10-NAME OF FATHER,

Louis Ray

11-BIRTHPLACE OF FATHER (State or Country).

Richmond

12-MAIDEN NAME OF MOTHER

Mary J. Thargmartin

13-BIRTHPLACE OF MOTHER (State or Country).

Richmond Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Dr. A. E. Mac Brown*(Address) *1905 N. Fulton Ave*

15-

SEP. 21 1915

HARRY O. ANDREWS

MARITAL PERMIT 0101

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 20, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 1st* 1915, to *Sept 20th* 1915, that I saw him alive on *Sept. 19* 1915, and that death occurred, on the date stated above, at *6:45 A.M.*

The CAUSE OF DEATH* was as follows:

Hypertrophy of the Heart with left ventricular compensation, complicated with arteriosclerosis(Duration) ... yrs. *4* mos. *20* ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *A. E. Mac Brown* M. D.*Sept. 20th* 1915. (Address) *1905 N. Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Ave

DATE OF BURIAL,

Sept 23 1915

20-UNDERTAKER

Wm Cook

ADDRESS

1026 N. Ark

C88320

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88320

CERTIFICATE OF DEATH

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Shakspeare ST. N WARD)2-FULL NAME Edward Przybylski

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

(Residence in Baltimore: No. 1623 Shakspeare St.; yrs. 6 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

6-DATE OF BIRTH Mar 22 1915
(Month) (Day) (Year)

7-AGE 6 yrs. 6 mos. 6 ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION None
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)Baltimore, Md.

PARENTS

10-NAME OF FATHER

Casmir Przybylski11-BIRTHPLACE OF FATHER
(State or country)German Poland

12-MAIDEN NAME OF MOTHER

Sophia Jurnaszewska13-BIRTHPLACE OF MOTHER
(State or country)Austria Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Casmir Przybylski

(Address)

1623 Shakspeare St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 20 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10, 1915, to, Sept 20 1915, that I saw him alive on Sept 19 1915, and that death occurred, on the date stated above, at 7:50 m. The CAUSE OF DEATH* was as follows:

DrowningContributory
(SECONDARY)

(Signed)

1915

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Stanislaus

DATE OF BURIAL

Sept 21, 1915

20-UNDERTAKER

M. F. Sadowski

ADDRESS

703 S. Ann. St.

SEP 21 1915

Filed

191

HARRY O. ANDERSON,

Marital Permit Clerk

REGISTRAR

C88321

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

105 C88321

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 W. Lombard St. 4 WARD)

2-FULL NAME

Sophie Cepatis

(Residence in Baltimore: No. 706 W. Lombard St. 3 yrs. - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

Sep 20 1912
(Month) (Day) (Year)

7-AGE

3 yrs. - mos. - ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (for employer)

None

9-BIRTHPLACE
(State or country)

City

10-NAME OF FATHER

Jules Macentas

11-BIRTHPLACE OF FATHER
(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Anne Cepatis

13-BIRTHPLACE OF MOTHER
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anne Cepatis

(Address) 706 W. Lombard St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept. 20, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Sept. 20, 1915, to Sept. 20, 1915

that I saw him alive on Sept. 20, 1915

and that death occurred, on the date stated above, at 8:00 p.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. 7 ds.

Contributory
(SECONDARY)(Signature) John A. Kladosky
Sept. 21, 1915 [Address] 639 W. Lombard St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 706 W. Lombard St.

19-PLACE OF BURIAL OR REMOVAL

St. Stanislawas

DATE OF BURIAL

Sept 21, 1915

20-UNDERTAKER

John Gebliawsky, 500 S. Park St.

15-SEP 21 1915

HARRY O. ANDREWS,

Bureau of Health, City of Baltimore
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Franklin Square Hotel* 13

REGISTERED No. C.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Herbert Bitzel

(Residence in Baltimore: No. *2635 Francis St.*

St., yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

march 6th, 1887
(Month) (Day) (Year)

7-AGE,

28 yrs. 6 mos. 14 ds.

If LESS than 1 day,

...hrs. or...mins.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Policeman

9-BIRTHPLACE,
(State or Country),

Md.

10-NAME OF FATHER,

Charles H. Bitzel

11-BIRTHPLACE OF FATHER
(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Elizabeth Brooks

13-BIRTHPLACE OF MOTHER
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Gertrude Bitzel*

(Address) *2635 Francis St.*

15-

HARRY O. ANDREWS

Filed

SEP. 21 1915

Serial *Parish* *Glory*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 20th, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry*
(Inquest, au-

Inquiry and that said deceased came to *death*
(topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Fall off street car accident

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Fractured skull

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Samuel Winkley* M. D.

Sept. 21st, 1915. (Address) *2302 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. *1/2 yr* In the *28 yrs. 6 mos. 14 ds.* State

Where was disease contracted, if not at place of death?

Edmondson Ave. x Arling. Long Ave

Former or usual residence *2635 Francis St.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Westminster Md

Sept 21 1915

20-UNDERTAKER

ADDRESS

H. J. Tichner & Sons

Penna x Wash

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88321

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 S. Ellwood Ave 1 ST. 1 WARD)

FULL NAME

James H. Swayne

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore, No. 713 S. Ellwood Ave

St. 1, yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

married

6-DATE OF BIRTH,

Dec 23

1873

(Month)

(Day)

(Year)

7-AGE,

72 yrs. 8 mos. 27 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Produce

(b) General nature of industry, business, or establishment in which employed (or employer).

business

9-BIRTHPLACE, (State or Country),

Md (Baltimore City)

10-NAME OF FATHER,

James H. Swayne

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Sarah Clark

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Sarah B. Swayne

(Address)

713 S. Ellwood Ave

15-

SEP 21 1915

HARRY O. ANDREWS,

Filed.....

1915

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 19, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

May 24, 1915, to Sept 19, 1915,

that I saw him alive on Sept 19, 1915,

and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Degenerative
Carcinoma of Bladder

(Duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) One yrs. mos. ds.

(Signed) J. J. Beckard M. D.

Sept 20, 1915. (Address) 5100 Oliver

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Pk. Bur.

Sept 22, 1915.

20-UNDERTAKER

ADDRESS

H. Sander & Sons

1710 Fleet St

88325

HEALTH DEPARTMENT—CITY OF BALTIMORE

88325

CERTIFICATE OF DEATH.

28
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1527 N Pratt*ST.; *19* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1527 N Pratt St*St.; *21* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day.

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

SEP 21 1915

HARRY O. ANDERSON,

Burial Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

C88326

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH.

(Month)

(Day)

(Year)

7-AGE.

22

8

3

mos.

da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Maker of steam hats

9-BIRTHPLACE,

(State or Country).

Baltimore

10-NAME OF FATHER,

Joseph J. Price

11-BIRTHPLACE OF FATHER

(State or Country).

Md.

12-MAIDEN NAME OF MOTHER

Maggie A. Saunders

13-BIRTHPLACE OF MOTHER

(State or Country).

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joe J. Price

(Address)

412 S. Pulaski

SEP 21 1915

Filed

191

HARRY O. ANDREWS

Baltimore Permit 0101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 20, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20, 1915, to Sept 20, 1915, that I saw him live on Sept 20, 1915, and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. J. O'Neill

Sept 20, 1915

(Address) 108 N. Hollen Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Mary's R.C. Church

DATE OF BURIAL

Sept 28, 1915

20-UNDERTAKER

John Brown

ADDRESS

901 Hollen Ave

C88327

HEALTH DEPARTMENT-CITY OF BALTIMORE

C88327

CERTIFICATE OF DEATH

PLACE OF DEATH *Baltimore City & H. Hosp*

REGISTERED NO. C

CITY OF BALTIMORE (No. *625* W. Franklin ST. *23* WARD)2-FULL NAME *William Murphy*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1404 Cooper* Sr. *6* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *single* (Write the word)6-DATE OF BIRTH *Unknown*, 1 (Month) (Day) (Year)7-AGE *6* yrs. mos. ds. or less than 1 day, hrs. or min.?8-OCCUPATION (a) Trade, profession, or particular kind of work *None* (b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE (State or country) *Balto Md*10-NAME OF FATHER *William Murphy*11-BIRTHPLACE OF FATHER (State or country) *Balto Md*12-MAIDEN NAME OF MOTHER *Annie Connor*13-BIRTHPLACE OF MOTHER (State or country) *Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William Murphy* (Address) *1404 Cooper Place*

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *Sept. 20, 1915* (Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Sept 15, 1915*, to *Sept 20, 1915*, that I saw him alive on *Sept 20, 1915*, and that death occurred, on the date stated above, at *12* m. The CAUSE OF DEATH* was as follows:*Meningitis (Septic)*Contributory - *Mastoiditis* (Duration) yrs. mos. *2* ds. (SECONDARY)(Signed) *Jessie Downey* M. D. (Duration) yrs. mos. *22* ds. (Address) - *529 N. Charles St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. *5* ds. In the *6* yrs. mos. ds. State *1404 Cooper St* Where was disease contracted, If not at place of death? *1404 Cooper St* Former or usual residence *1404 Cooper St*19-PLACE OF BURIAL OR REMOVAL *St. Peter's Cemetery*DATE OF BURIAL *Sept 23, 1915*20-UNDERTAKER *Wm. J. Conant*ADDRESS *901 Holliday*

15-SEP 21 1915 HARRY O. ANDREWS, Registrar

Very important - See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88329

CERTIFICATE OF DEATH

C88329

PLACE OF DEATH 1623 Elizabeth Lane

REGISTERED NO. C.....

CITY OF BALTIMORE: (No.)

ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and SN out No. 18.)

2-FULL NAME

John J. N. Phillips

(Residence in Baltimore: No.)

1623 Elizabeth Lane

St.; - yrs. 1 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

July

24

1915

(Month)

(Day)

(Year)

7-AGE

-

yrs.

1

mos.

27

ds.

or

min.?

If LESS than

1 day, hrs.,

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE

(State or country)

Baltimore, Md.

10-NAME OF FATHER

William P. Phillips

11-BIRTHPLACE OF FATHER

(State or country)

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Elizabeth Stump

13-BIRTHPLACE OF MOTHER

(State or country)

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William P. Phillips

(Address)

1623 Elizabeth Lane

15-

Filed

SEP 21 1915

191

Burial Permit 019

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September

20

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 8, 1915

to

Sept. 17, 1915

1915

that I saw him alive on September 17, 1915

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Lues, congenital

Contributory (SECONDARY)

(Duration)

yrs

1

mos.

27

ds.

(Signed)

(Duration)

yrs

-

mos.

9

ds.

Sept. 21, 1915

[Address]

529 N. Charles St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Hill Cemetery

Sept. 21, 1915

20-UNDERTAKER

ADDRESS

Mrs. J. E. Evans

1420 S. Charles St.

C88330

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 C88330

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

2568 N. Baeto

ST. 20 WARD)

2-FULL NAME

Charles Eldridge Fauschaw

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

2568 N. Baeto

St.; - yrs. 11 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH Oct 15, 1914 (Month) (Day) (Year)

7-AGE 11 yrs. 4 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Baeto Md

10-NAME OF FATHER Joe E. Fauschaw

11-BIRTHPLACE OF FATHER (State or country) Baeto Md

12-MAIDEN NAME OF MOTHER Minnie Albecker

13-BIRTHPLACE OF MOTHER (State or country) Baeto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joe E. Fauschaw

(Address)

2568 N. Baeto St

SEP 21 1915

HARRY O. ANDREWS

Marial Permit Clerk

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 14 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 18, 1915, to Sept 14, 1915.

that I saw him alive on Sept 18, 1915, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Acute Gastric Enteritis

Contributory (SECONDARY)

Sept 18, 1915 (Duration) yrs. 2 mos. 2 ds.

(Signed)

M. D. M. D.

Sept 18, 1915 (Address) 2568 N. Baeto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cemetery

Sept 21, 1915

20-UNDERTAKER

ADDRESS

F. B. Wyper 2235 Fredk Ave

C88331

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88331

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. _____)

FULL NAME

(Residence in Baltimore: No. _____)

Southern District
John F. Washenfelter
1224 Marshall St

REGISTERED No. C

WARD

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
6-DATE OF BIRTH April 2, 1878		
7-AGE 37 yrs., 4 mos., 16 ds.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Laborer		
9-BIRTHPLACE (State or Country) Baltimore		
PARENTS.	10-NAME OF FATHER Leopold Washenfelter	
	11-BIRTHPLACE OF FATHER (State or Country) Germany	
	12-MAIDEN NAME OF MOTHER Christina P.	
	13-BIRTHPLACE OF MOTHER (State or Country) Germany	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

SEP 21 1915

Marital Permit Office

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Wounded
Pistol shot wound in breast
Pistol in the hands of the deceased

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) Leopold Washenfelter M. D.
(Coroner.)
Sept 21, 1915. (Address) 1217 Leaden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Western Ave

Sept 21 1915

20-UNDERTAKER

ADDRESS

Wm. L. Loo

1078 N. Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 Cleveland ST.; 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1231 Cleveland St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH.

Feb 30, 1850
(Month) (Day) (Year)

7-AGE.

65 yrs., 2 mos., 21 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Engineer9-BIRTHPLACE.
(State or Country).Howard Co. Md

10-NAME OF FATHER.

John Lilly11-BIRTHPLACE OF FATHER
(State or Country).Balto Co Md

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country).Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs. Catherine Lilly
1231 ClevelandFiled SEP 21 1915

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 20 1915, to Sept 21 1915that I saw him alive on Sept 21 1915,and that death occurred, on the date stated above, at 4 4 m.

The CAUSE OF DEATH* was as follows:

Analysis of Frank
Shaw
(Duration) 8 yrs., 2 mos., 21 ds.CONTRIBUTORY
(Secondary)asthma & emphysema
(Duration) 10 yrs., 2 mos., 21 ds.
(Signed) Alfred D. Starn M. D.
Sept 21 1915 (Address) 1227 Clinton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Landen Farm Cemetery

DATE OF BURIAL.

Sept 23, 1915

20-UNDERTAKER

John J. Brown & Son

ADDRESS

107 Holler St.

C88333

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 7 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. 60 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

6-DATE OF BIRTH Aug. 15, 1829 (Month) (Day) (Year)

7-AGE 86 yrs. 1 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Tailor

9 BIRTHPLACE (State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie Schiffhauer

(Address)

917 N. Bond St.

15.

FILED

SEP 21 1915

ROBERT J. KRAUTH

BALTIMORE PERMIT CLERK

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 20th, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1915 to Sept 20th, 1915

that I saw him alive on Sept 1st, 1915 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Signed)

Sept 20th, 1915 Address 1501 E. English St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Sep 22, 1915

20 UNDERTAKER

ADDRESS

A. Fink & Son

915 N. Gay St.

Very important - See instructions on back of certificate.

C88331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

1915

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquiry*
(Inquest, au-topsy or inquiry.) and that said deceased came to *death*
on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Elyah J. Russell* M. D.Sept. 21, 1915. (Address) *423 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *1215 Mulliken* ST.; *5* WARD)

FULL NAME

(Residence in Baltimore: No. *1215 Mulliken*

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *Life* yrs., *7* mos., *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*col*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

unknown

(Month)

(Day)

(Year)

7-AGE,

54

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Trigon Division

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Samuel Dorsey

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER,

May Isaacs

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annie Dorsey*(Address) *1215 Mulliken*

15-

SEP 21 1915

Filed..... 191

ROBERT H. KRAUTH

BALTIMORE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 19, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

*July 16 1915 to Sept 19 1915*that I saw him alive on *Sept 18 1915*and that death occurred, on the date stated above, at *10.30 a.m.*

The CAUSE OF DEATH* was as follows:

Bright's Dis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *N. C. Burns*

M. D.

Sept 20, 1915. (Address) 2218 Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Evergreen Cemetery, Sept 21, 1915

20-UNDERTAKER ADDRESS

Chris. H. Johnson 416 N. Carroll

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *509 S. Milton M.* ST.; *1* WARD)2-FULL NAME *Cornelius Harris*(Residence in Baltimore: No. *509 S. Milton M.* St.; *59* yrs., *10* mos., *ds.*)28 088333
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

Married

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

*Nov**1855*

(Month)

(Day)

(Year)

7-AGE

*62**10* yrs., *10* mos., *ds.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Ship**Carpenter*9-BIRTHPLACE,
(State or Country),*Balta Md.*

10-NAME OF FATHER,

Wm Harris

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary Harris

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Minnie Harris*(Address) *509 S. Milton M.*

15-

SEP 21 1915

ROBERT KRAUTER

BALTIMORE PERMITS CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *Nov 13* 191*4* to *Sept 17* 191*5*,that I saw him alive on *Sept 18* 191*5*, and that death occurred, on the date stated above, at *2:15* p.m.

The CAUSE OF DEATH* was as follows:

*Pulmonary Tuberculosis**about* (Duration) *1* yrs., *10* mos., *ds.*

CONTRIBUTORY (Secondary)

apmt(Duration) *1* yrs., *10* mos., *ds.*(Signed) *J. H. H. H.* M. D.*9/20*, 191*5*. (Address) *1937 Gough St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs., *10* mos., *ds.* In the State *1* yrs., *10* mos., *ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

Sept 22, 1915

20-UNDERTAKER

John A. Moran & Sons

ADDRESS

Bank

HEALTH DEPARTMENT--CITY OF BALTIMORE

PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Residence in Baltimore: No.

St. 70 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE

MARRIED

WIDOWED

DIVORCED

(Write the word)

DATE OF BIRTH

AGE

If LESS than

1 day, hrs.,

or min.?

OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)BIRTHPLACE
(State or country)

NAME OF FATHER

BIRTHPLACE OF FATHER
(State or country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(State or country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

, 191, to, 191,

that I saw h. ex. alive on Sept 17, 1915,

and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis
Unknown (Duration) yrs. mos. ds.Contributory (SECONDARY) Val. Dev. of heart
(Duration) yrs. mos. ds.(Signed) F. A. Warner, M. D.
Sept 20, 1915 [Address] 1133 Valley m.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 6 yrs. mos. ds. In the State 70 yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence Little Sisters of the Poor.

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cathedral Sept 21, 1915.

UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Green Mt. Ave.

SEP 21 1915
Filed 191HUBERT J. KRAUTH
REGISTRAR

HEALTH DEPARTMENT--CITY OF BALTIMORE

88339

CERTIFICATE OF DEATH

79 88339

1-PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C

CITY OF BALTIMORE: (No.

St. 10

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Agnes Curran

(Residence in Baltimore: No.

Little Sisters of the Poor

St. 63 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR-DIVORCED

(Write the word)

Widow

6-DATE OF BIRTH

(Month)

(Day)

(Year)

1843

7-AGE

72

mos.

da.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or country)

Ireland

10-NAME OF FATHER

Michael Hogan

11-BIRTHPLACE OF FATHER
(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Bridget-McMann

13-BIRTHPLACE OF MOTHER
(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

ROBERT J. ZRAUTER

MUNICIPAL PERMIT CLERK

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept

21

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 21

1915

that I saw him alive on Sept 18, 1915, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Valvular dis. of heart

Unknown

(Duration)

yrs.

mos.

da.

Contributory
(SECONDARY)

Drop

(Duration)

yrs.

mos.

da.

(Signed)

J. H. Allen

M. D.

Sept 21, 1915

[Address]

1133 Valley St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place

of death

5

yrs.

5

mos.

In the

63

yrs.

mos.

da.

State

yrs.

mos.

da.

Where was disease contracted,

if not at place of death?

Former or

usual residence

Little Sisters of the Poor

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Vincent's Ben

Sept 23

1915

20-UNDERTAKER

ADDRESS

McGinnick & Canoll 608 N. Potomac

SEP 21 1915

Filed

191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *122 East*)

FULL NAME *Edith Mack*

(Residence in Baltimore: No. *122 East*)

St. *5* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *8* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

35

yrs. mos. ds.

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laundress

9-BIRTHPLACE,

(State or Country),

City. Balt.

10-NAME OF FATHER,

Henry Mack

11-BIRTHPLACE OF FATHER

(State or Country),

Va

12-MAIDEN NAME OF MOTHER

Mary Johnson

13-BIRTHPLACE OF MOTHER

(State or Country),

Me.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edith Mack*

(Address) *122 East St.*

15-

Filed

SEP 21 1915

191

ROBERT KRAUTER

Health Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September

(Month)

20, 191*5*.

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.)

and that said deceased came to *his* death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis

(Duration) yrs. mos. ds.

(Signed) *Thos. H. Thompson* M. D.

(Coroner.)

191*5* (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

Asbury

DATE OF BURIAL,

Sept 22 1915

20-UNDERTAKER

John W. Henderson

ADDRESS

3176 Carver

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *303 S. Wolfe*)

FULL NAME

Henry E. Quaster (Quaster)

(Residence in Baltimore: No. *303 S. Wolfe*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. *33* mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
4-COLOR OR RACE, *white*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)
6-DATE OF BIRTH, *Sept. 20, 1845*
(Month) (Day) (Year)
7-AGE, *70* yrs. *5* mos. *11* ds.
If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Retired*
(b) General nature of industry, business, or establishment in which employed (or employer), *Iron works*

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. Maure*

(Address) *11341 Harbor Rd.*

15-

Filed

SEP 21 1915

ROBERT J. KRAUTH

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *September 12, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*
(Inquest, autopsy or inquiry.)

And that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *David W. Jones* M. D.
(Coroner.)

Sept. 21, 1915 (Address) *3116 Edsonville St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,

Calhoun

DATE OF BURIAL,

Sept. 21, 1915

20-UNDERTAKER

Lilly-Zeiler

ADDRESS

4033 Wolfe

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Mary Hospital* ST. *4* WARD)

2-FULL NAME *Harry Gillease*

(Residence in Baltimore: No. *Mary Hospital*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. *5* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Aug 30th, 1896
(Month) (Day) (Year)

7-AGE,

19 yrs. *21* mos. *21* da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Balto Co. Md.

10-NAME OF FATHER,

James Gillease

11-BIRTHPLACE OF FATHER (State or Country),

Harford Co.

12-MAIDEN NAME OF MOTHER

Annie Heinen

13-BIRTHPLACE OF MOTHER (State or Country),

Balto. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James Gillease

(Address)

815 S. 5th St.

15-

Filed

SEP 21 1915

ROBERT . KRAUTH,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 20, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry* (Inquiry, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry* (Inquest, or

inquiry and that said deceased came to *his* death (Inquest, or inquiry.) on the day stated above.

The CAUSE OF DEATH was as follows:

Accident - fracture skull - due to fall off wagon

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. Chambers M. D. (Coroner)

Sept. 21, 1915

(Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. *5* da. State... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence *Highlandtown, Md.*

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn

DATE OF BURIAL,

Sept. 20, 1915

20-UNDERTAKER

Lilly Zeller

ADDRESS

4038 Maple St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 Hollington St.)

2-FULL NAME

(Residence in Baltimore: No. 925 Hollington St.)

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Not known, 1

7-AGE

48 yrs. 48 mos. 48 ds.

If LESS than 1 day,
hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Tailor

9-BIRTHPLACE,
(State or Country).

Bohemia

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Stashy

(Address) 925 Hollington St.

15-

SEP 21 1915

Filed

191

ROBERT

KRAUTH,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 21, 1915

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1915, to Sept 21, 1915, that I saw him alive on Sept 20, 1915, and that death occurred, on the date stated above, at 1:10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY
(Secondary)

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed) Emma Novak M. D.
Sept 21, 1915 (Address) 823 N. 10th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL

Sept 21, 1915

20-UNDERTAKER

Frank Crochodny

ADDRESS

1046 W. 10th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. *Meriden Hospital* ST.;

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Rosie Ozehowski*(Residence in Baltimore: No. *835 S. Bond St.*

St.; / yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Dec 1*, 1913

(Month)

(Day)

(Year)

7-AGE, *1* yrs., *7* mos., *20* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Philadelphia, Pa.*10-NAME OF FATHER, *Leopold Ozehowski*11-BIRTHPLACE OF FATHER (State or Country), *Russia Poland*12-MAIDEN NAME OF MOTHER, *Ladislawa Nachelska*13-BIRTHPLACE OF MOTHER (State or Country), *Russia Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ladislawa Ozehowski*(Address) *835 S. Bond St.*

15-

Filed

SEP 21 1915

ROBERT J. KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, *September 21*, 1915

(Month)

(Day)

(Year)

11-I HEREBY CERTIFY, That I attended deceased from *Sept. 17*, 1915, to *Sept. 21*, 1915, that I saw her alive on *Sept. 21*, 1915, and that death occurred, on the date stated above, at *12:20 P.*

The CAUSE OF DEATH* was as follows:

Enteric Colitis(Duration) *Seven weeks*

CONTRIBUTORY (Secondary)

(Duration) *Five* yrs., *mos.*, *ds.*(Signed) *Frank M. M...* M. D.9-21-15:01... (Address) *Meriden Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *5* yrs., *mos.*, *ds.* In the State *5* yrs., *mos.*, *ds.*Where was disease contracted, if not at place of death? *835 S. Bond St.*Former or usual residence *835 S. Bond St.*19-PLACE OF BURIAL OR REMOVAL, *St. Stanislaw*DATE OF BURIAL, *Sept 22*, 191520-UNDERTAKER, *M. J. Sadowski*ADDRESS, *705 S. Ann*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 S. Ann ST.;

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Lejowski(Residence in Baltimore: No. 316 S. Ann St.;yrs. 7 mos. 23 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH,

January 28, 1915
(Month) (Day) (Year)

7-AGE,

7 yrs. 2 mos. 23 da.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), Baltimore Md10-NAME OF FATHER, Stephen Lejowski11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md12-MAIDEN NAME OF MOTHER Rose Ryborski13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephen Lejowski(Address) 316 S. Ann St

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

August 28th 1915, to Sept 21 1915,that I saw him alive on Sept 21 1915,and that death occurred, on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis & shock
colitis(Duration).....yrs. 1 mos. 3 ds.CONTRIBUTORY Hunt. Failure & exhaustion
(Secondary)(Duration).....yrs.mos. 3 ds.(Signed) Thos. A. Matthews M. D.9/21....., 1915 (Address) 422 S. Ann St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

Sept 22, 1915

20-UNDERTAKER

M. J. Sadowski

ADDRESS

405 S. Ann St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2407 E. Hoffman* ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2407 E. Hoffman* St.; *8* yrs., *1* mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Aug 14 1915
(Month) (Day) (Year)

7-AGE,

1 mos. 6 ds.
..... yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Chas Krieg

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Maynard Hammond

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *Chas Krieg*(Address)..... *2407 E. Hoffman*

15-

SEP 22 1915

Filed.....

191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 21 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Aug 14 1915, to *Sept 21 1915*,that I saw him alive on *Sept 20 1915*,and that death occurred, on the date stated above, at *3 P* m.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....

..... (Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs. mos. ds.

(Signed)..... *Edmund* M. D.*Sept 22, 1915*. (Address)..... *517 Scott St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

Johns River

DATE OF BURIAL,

Sept 22, 1915

20-UNDERTAKER

Robt Turner

ADDRESS

1824 My

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1504 Harlem Ave.

ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME

Mary J. Spear

(Residence in Baltimore: No. 1504 Harlem Ave.

St. 16 yrs. 65 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widow

6-DATE OF BIRTH

Dec.

23, 1825

(Month)

(Day)

(Year)

7-AGE

89 yrs. 8 mos. 27 ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or country)

Pa

10-NAME OF FATHER

J. E. Roulon

11-BIRTHPLACE OF FATHER (State or country)

France

12-MAIDEN NAME OF MOTHER

Jane Meyer

13-BIRTHPLACE OF MOTHER (State or country)

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. B. B. Lynch

(Address)

1504 Harlem Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept

20, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1915 to Sept 21, 1915.

that I saw him alive on Sept 21, 1915 and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Gun Barrel Obstruction

Contributory (SECONDARY)

Old age (Duration) yrs. 4 mos. 4 ds.

(Signed)

J. M. A. Egan M. D. 9-22, 1915 (Address) Payette Gary St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 65 mos. 20 ds. In the State yrs. 65 mos. 20 ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Greenmount Cem

DATE OF BURIAL

Sept 22, 1915

20-UNDERTAKER

W. J. Fickner

ADDRESS

North & Perry

is very important, See instructions on back of certificate.

15-SEP 22 1915

Filed, 191

HARRY O. ANDREWS

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88349

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1630 N. Bruce*ST.; *15* WARD)

REGISTERED NO. C

2-FULL NAME

Hilda White

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1630 N. Bruce*St.; yrs. *4* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

*Caucasian*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

yrs. *4* mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Baby*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*Harmon White*11-BIRTHPLACE OF FATHER
(State or Country),*MD*

12-MAIDEN NAME OF MOTHER

*Mamie Cross*13-BIRTHPLACE OF MOTHER
(State or Country),*MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-SEP 22 1915

Filed..... 191

HARRY O. ANDERSON

Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sep 20, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Sep 7* 1915 *Sep 20* 1915that I saw her alive on *Sep 18* 1915and that death occurred, on the date stated above, at *5:00* m.

The CAUSE OF DEATH* was as follows:

acute enteritis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... M. D.

9-21, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Laurel Cemetery *Sept 22, 1915*

20-UNDERTAKER ADDRESS

James H. Dennis *1300 N. Bruce*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88350

CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2508 Ellamont Ave. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2508 Ellamont Ave. St.; 17 yrs., 7 mos., 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

March 5th, 1872
(Month) (Day) (Year)

7-AGE,

42 yrs., 6 mos., 15 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,

(State or Country),

Harford Co. Md.

10-NAME OF FATHER,

Edw. C. Tolley

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Anna Moore

13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry M. Leary(Address) 2508 Ellamont Ave.

15-

SEP 22 1915

HARRY O. ANDREWS,

Filed..... 1915

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September, 20, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 13 1915, to Sept 20 1915,that I saw her alive on Sept 20 1915,and that death occurred, on the date stated above, at 7 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

.....

.....

..... (Duration)..... yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary)

Myocardial insufficiency..... (Duration)..... yrs. 20 mos. 20 ds.(Signed) John T. King M. D.Sept 22, 1915 (Address) 1425 Eastern Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. 20 mos. 20 ds. In the State..... yrs. 20 mos. 20 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Lorraine Cemetery Sept 23, 1915.

20-UNDERTAKER

ADDRESS

E. M. Mitchell & Co 120 N. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1508 Poplar Grove street ST. 15 WARD)

FULL NAME William Joachim,

(Residence in Baltimore: No. 1508 Poplar Grove street, St.; yrs. 40 mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male,	4-COLOR OR RACE, White,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH, May 9th, 1854. (Month) (Day) (Year)		
7-AGE, 61 yrs. 4 mos. 11 ds.		8-LESS than 1 day, hrs. or min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), Germany,		
PARENTS.	10-NAME OF FATHER, Carl F. Joachim,	
	11-BIRTHPLACE OF FATHER (State or Country), Germany,	
	12-MAIDEN NAME OF MOTHER Unknown,	
	13-BIRTHPLACE OF MOTHER (State or Country), Germany,	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sophie Joachim, wife.
(Address) 1508 Poplar Grove street.

15-SEP 22 1915
Filed 1915
BARRY G. ANDREWS
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,
September 21st, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pistolshot wound of head.
((Suicide))
(Duration) yrs. mos. ds.
CONTRIBUTORY Melancholia,
(Secondary)
(Duration) yrs. mos. ds.
(Signed) Frederick J. Campbell, M. D.
(Coroner.)
Sept. 21, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *106 W. Cross* ST.; *23* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Helen Kabakovich

(Residence in Baltimore: No.

*106 W. Cross*St.; *1* yrs., *10* mos. *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

Infant

6-DATE OF BIRTH,

Nov 4, 1914
(Month) (Day) (Year)

7-AGE,

10 mos. 18 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Infant*

9-BIRTHPLACE, (State or Country),

Maryland (City)

10-NAME OF FATHER,

Jack Kabakovich

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Dominica Massarety

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jack Kabakovich

(Address)

106 W. Cross

15-

SEP 22 1915

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 22, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept - 15, 1915*, to *Sept, 22, 1915*, that I saw her alive on *Sept - 16 - 1915*, and that death occurred, on the date stated above, at *5-4* m.

The CAUSE OF DEATH* was as follows:

acute gastro-enteric intoxication(Duration)..... yrs..... mos. *14* ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

*E. J. Friedman, M. D.**Sept, 22, 1915* (Address) *122 W. Lee St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St Stanislaw

DATE OF BURIAL,

Sept. 22, 1915

20-UNDERTAKER

John G. G. G. G.

ADDRESS

500 S. Park St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *803 Raborg* ST.: *18* WARD)

FULL NAME.

(Residence in Baltimore: No. *803 Raborg*)

REGISTERED NO. C *79*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *—* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Col* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow*
(Write the word.)
6-DATE OF BIRTH, *May 31, 1862*
(Month) (Day) (Year)

7-AGE, *52* yrs., *3* mos., *20* ds. If LESS than 1 day, *—* hrs. or *—* min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Laundress*
(b) General nature of industry, business, or establishment in which employed (or employer), *—*

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *James Bryan*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary R. Brown*

(Address) *1217 Bayard St*

15-SEP 22 1915 HARRY C. REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 20, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) *—* yrs., *—* mos., *—* ds.

CONTRIBUTORY (Secondary) *Organic Heart Disease*

(Duration) *—* yrs., *—* mos., *—* ds.

(Signed) *W. H. Leffler* M. D.

(Coroner.) *W. H. Leffler* (Address) *312 Cambridge St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs., *—* mos., *—* ds. In the *—* yrs., *—* mos., *—* ds.

Where was disease contracted, if not at place of death? *—*

Former or usual residence *—*

19-PLACE OF BURIAL OR REMOVAL, *Green Willow Cemetery* DATE OF BURIAL, *Sept 23, 1915*

20-UNDERTAKER, *Geo H. Heald* ADDRESS, *609 Little Rock St*

C88354

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

29

C88354

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 309 State

ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Cornelius Pratt

(Residence in Baltimore: No. 309 State St

St. 2 4 yrs. 9 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

colored

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

6-DATE OF BIRTH

November 24, 1890
(Month) (Day) (Year)

7-AGE

24 yrs. 9 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Pin-boy
bowling alley9-BIRTHPLACE
(State or country)

Baltimore, Md.

10-NAME OF FATHER

Samuel Pratt.

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Ida Williams

13-BIRTHPLACE OF MOTHER
(State or country)

Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Kate Pratt.

(Address)

309 State St.

15.

SEP 22 1915

HARRY O. ALLEN
Burial Permit 01915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September 20, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 2, 1915, to Sept. 20, 1915, that I saw him alive on Sept 17, 1915, and that death occurred, on the date stated above, at 4:00 a.m. The CAUSE OF DEATH* was as follows:

acute pneumonic phthisis

(Duration) — yrs. 3 mos. — ds.

Contributory
(SECONDARY)

none

(Duration) — yrs. — mos. — ds.

(Signed),

Chester Riland

M. D.

Sept 20, 1915 (Address) 2532 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

M. J. J. J. J.

Sept 22, 1915

20-UNDERTAKER

Samuel H. H. H.

ADDRESS

678 W. Biddle

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88355

C88355

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, *Single*

MARRIED

WIDOWED

OR DIVORCED

(If write the word)

6-DATE OF BIRTH

(Month)

(Day)

(Year)

7-AGE

yrs. 10 mos. 26 ds.

If LESS than

1 day, hrs.

or min. ?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

PARENTS

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month)

(Day)

(Year)

17.

I HEREBY CERTIFY. That I attended deceased from

6 Sept. 1915, to 20 Sept. 1915.

that I saw him alive on 19 Sept. 1915.

and that death occurred on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(Duration) yrs. 1 mos. ds.

Contributory

(SECONDARY)

Septicemia

(Duration) yrs. 14 mos. ds.

(Signed) M. C. Sandrock

M. D.

Sept 21, 1915 (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

In the

ds. State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral

Sept 22, 1915

20-UNDERTAKER

ADDRESS

William Cook

502 E North

15.

SEP 22 1915

Filed

191

BARRY D. AMERSON

Bureau of Vital Statistics

REGISTRAR

is very important. See instructions on back of certificate.

8 C88356

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

61 C88356

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *501 Battery Ave*)

WARD) *24*

2-FULL NAME *Clara C. Daeth*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *501 Battery Ave*)

St. yrs. *6* mos. *20* ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED *Single* WIDOWED OR DIVORCED (Write the word)

16-DATE OF DEATH *Sept 21, 1915*
(Month) (Day) (Year)

6-DATE OF BIRTH *Mar 1, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 21st*, 1915, to *Sept 21st*, 1915, that I saw her alive on *Sept 21st*, 1915, and that death occurred, on the date stated above, at *11 A.m.* The CAUSE OF DEATH* was as follows:

7-AGE *6* yrs. *20* mos. *20* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *None* (b) General nature of industry, business, or establishment in which employed (or employer)

Acute Cerebro-spinal meningitis (infectious)
(Duration) yrs. mos. ds. *3* mos. *3* ds.
Contributory *Acute Cerebro-spinal meningitis*
(Duration) yrs. mos. ds. *3* mos. *3* ds.
(Signed) *J. F. Murphy* M.D.
Sept 22, 1915 (Address) *18 Remond St*

9-BIRTHPLACE (State or country) *Batts. Md*

10-NAME OF FATHER *Mr. C. Daeth*

11-BIRTHPLACE OF FATHER (State or country) *Batts. Md*

12-MAIDEN NAME OF MOTHER *Ann. Van Vollen*

13-BIRTHPLACE OF MOTHER (State or country) *Batts. Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Mr. C. Daeth* (Address) *501 Battery Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Cathedral Ave* DATE OF BURIAL *Sept 23, 1915*

20-UNDERTAKER *Mr. J. J. ...* ADDRESS *38 E. ...*

15 SEP 22 1915 Filed 191

JOHN H. KRAUTER REGISTRAR

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 57 N. Carey St. ST. 18 WARD)2-FULL NAME Irene Cornelia Morrison(Residence in Baltimore: No. 57 N. Carey St. St. 43 yrs. — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female4-COLOR OR RACE. White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
(Write the word.)6-DATE OF BIRTH. September ?, 1840

(Month)

(Day)

(Year)

7-AGE. 75 ? ?

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None(b) General nature of industry, business, or establishment in which employed (or employer). None9-BIRTHPLACE, (State or Country). Maryland10-NAME OF FATHER. John Sifford11-BIRTHPLACE OF FATHER. Penna.12-MAIDEN NAME OF MOTHER. not known13-BIRTHPLACE OF MOTHER. not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. J. F. Morrison(Address) 57 N. Carey St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 21st, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from July 5th 1910, to Sept 20th 1915, that I saw her alive on September 18 1915, and that death occurred, on the date stated above, at 6⁴⁵ m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart(Duration) 5 yrs. 3 mos. — ds.CONTRIBUTORY (Secondary) Pathologic Degeneration(Duration) — yrs. — mos. — ds.(Signed) Wm. H. Krauth M. D.Sept 21st, 1915. (Address) 252 N. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Fredrick, Md.DATE OF BURIAL. Sept 22nd, 191520-UNDERTAKER. Stewart H. HowellsADDRESS. 108 W. North St.

15-

Filed

SEP 22 1915

191

ROBERT KRAUTH
BRIAL PERMIT OFFICE

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *11 W Mulberry*, ST. *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary Catherine Werner*(Residence in Baltimore: No. *11 W. Mulberry* St.: *10* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, *Single* WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *March 7th, 1874*
(Month) (Day) (Year)

7-AGE, *41* yrs. *6* mos. *14* ds. If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Dress maker*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Albany New York*

10-NAME OF FATHER, *William Werner*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Hannah A. Glover*

13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Margaret Werner*(Address) *11 W. Mulberry St.*

15-SEP 22 1915

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 11th, 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *May 4th, 1915*, to *Sept 21st, 1915*, that I saw her alive on *Sept 21st, 1915* and that death occurred, on the date stated above, at *10.30 PM* m.

The CAUSE OF DEATH* was as follows:

Bilateral pneumonia
(Duration).....yrs. *4* mos.ds.

CONTRIBUTORY.....
(Secondary)

(Signed) *James D. Byrne* M. D.
Sept 21st, 1915 (Address) *570 Park Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*New Cathedral**Sept 24, 1915*

20-UNDERTAKER

ADDRESS

*Hoffert's Co**McGulloch St*

C88359

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 932 Fall street St.;yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) Single

6-DATE OF BIRTH.

March22, 1915.
(Month) (Day) (Year)

7-AGE,

7 yrs. 7 mos. ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

John Adamski11-BIRTHPLACE OF FATHER
(State or Country),Poland

12-MAIDEN NAME OF MOTHER

Bessie Wana13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. Roszel(Address) Johns Hopkins Hospital

15-

Filed

SEP 22 1915

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 22

(Month)

(Day)

1915.
(Year)17- I HEREBY CERTIFY, That I attended deceased from Sept. 19 1915, to Sept 22 1915, that I saw him alive on Sept. 22 1915, and that death occurred, on the date stated above, at 11 PM m.

The CAUSE OF DEATH* was as follows:

Intoxication, intestinal(Duration) yrs. mos. 1 1/2 ds.CONTRIBUTORY
(Secondary)Alcoholism(Duration) yrs. mos. 7 ds.

(Signed)

J. F. Powers

M. D.

Sept. 22 1915. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State 1 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

932 Fall street

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaw

DATE OF BURIAL,

Sept 23, 1915.

20-UNDERTAKER

M. J. Sadowski

ADDRESS

705 S. Ann St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88360

CERTIFICATE OF DEATH.

104 C88360

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hosp

ST.

17

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Raymond Stevens

(Residence in Baltimore: No.

1133 Division Street

St.; yrs. + mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

June

(Month)

25

(Day)

1915

(Year)

7-AGE,

yrs. 2

mos. 27

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

New Jersey

10-NAME OF FATHER,

Theodore Stevens

11-BIRTHPLACE OF FATHER

(State or Country),

md.

12-MAIDEN NAME OF MOTHER

Emma Mason

13-BIRTHPLACE OF MOTHER

(State or Country),

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

A. J. Smith

(Address)

Johns Hopkins Hospital

15-SEP 23 1915

Filed

191

BALTIMORE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September

(Month)

21

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from September 14 1915, to September 21 1915, that I saw him alive on September 21 1915, and that death occurred, on the date stated above, at 6:57 P.M.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(Duration)

yrs.

mos.

7 ds.

CONTRIBUTORY

(Secondary)

(Duration)

yrs.

mos.

2 ds.

(Signed)

J. F. Powers

M. D.

Sept. 22, 1915.

(Address)

Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

7 ds.

In the

State

of

yrs.

mos.

21 ds.

Where was disease contracted, if not at place of death?

1133 Division St

Former or usual residence

1133 Division Street

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn Cemetery

DATE OF BURIAL,

Sept 23 1915

20-UNDERTAKER

Robert B. Pye

ADDRESS

1026 Hullbury St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88361

CERTIFICATE OF DEATH.

104 C88361
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2116 Fleet* ST. *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Frank Faby*(Residence in Baltimore: No. *2116 Fleet* St. *1* yrs. *1* mos. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH *Aug 16 1914*

(Month)

(Day)

(Year)

7-AGE *1 1 7*

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Frank Faby*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Mary Bunk*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Faby*(Address) *2116 Fleet*

15-

Filed *SEP 23 1915*HARRY O. ANDERSON
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 22 1915*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *Sept 5* 191*5*, to *Sept 23* 191*5*,that I saw him alive on *Sept 23* 191*5*,and that death occurred, on the date stated above, at *834*

The CAUSE OF DEATH* was as follows:

*Enterocolitis*CONTRIBUTORY (Secondary) *Boiling Exhaustion*(Signed) *W. J. Sauer*

M. D.

9-22-15

(Address) *2008 Ashland*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St Stanislaus*DATE OF BURIAL, *Sept 23 1915*20-UNDERTAKER, *William Salfowick*ADDRESS, *1618 Eastern Ave*

C88362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 C88362

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Wyanoke Ave.

ST.: 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joanna C. Siwinski,

(Residence in Baltimore: No. 606 Wyanoke Ave.

St.: 32 yrs., - mo. - da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

May

27

1880

(Month)

(Day)

(Year)

7-AGE,

35

yrs.

3

mo.

25

da.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

At Home.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), German Poland,

10-NAME OF FATHER,

John Dulski,

11-BIRTHPLACE OF FATHER

German Poland,

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Geo. W. Siwinski.

(Address)..606 Wyanoke Ave.

15-SEP 23 1915

Filed..... 1915

HARRY O. ANDERSON

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

22

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1, 1915, to Sept 22, 1915,

that I saw her alive on Sept 22, 1915,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 6 yrs. mo. da.

CONTRIBUTORY (Secondary)

(Duration) 6 yrs. mo. da.

(Signed) John Dulski

M. D.

9/22, 1915 (Address) 502 Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mo. da. In the State yrs. mo. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cemetery

DATE OF BURIAL,

Sept 24, 1915

20-UNDERTAKER

William Fialkowski

ADDRESS

1618 Eastern Ave,

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88363

C88363

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Nos.* ST.; *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Jess. Williams*(Residence in Baltimore: No. *401 Vincent alley* St.; *3* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE,

*Black*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown, 1893
(Month) (Day) (Year)

7-AGE,

22 yrs., mos., ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *Labourer*
(b) General nature of industry, business, or establishment in which employed (or employer)...9-BIRTHPLACE,
(State or Country),*Gulfport, Md.*

10-NAME OF FATHER,

*James William*11-BIRTHPLACE OF FATHER
(State or Country),*Gulfport Md*

12-MAIDEN NAME OF MOTHER

*Don't know*13-BIRTHPLACE OF MOTHER
(State or Country),*md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James William*(Address) *401 N. Vincent St.*

15-

SEP 23 1915

HARRY O. ANDREWS,

Filed

191

Baptist Parish Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 20, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *Sept 12* 1915, to *Sept 20* 1915, that I saw him alive on *Sept 20* 1915, and that death occurred, on the date stated above, at *9 A.* m.

The CAUSE OF DEATH* was as follows:

Typhoid fever(Duration) yrs. *2* mos. *20* ds.CONTRIBUTORY *Perforation of bowels*
(Secondary)(Duration) yrs. *2* mos. *2* ds.(Signed) *Geo. G. Snarr* M. D.*Sept 20, 1915* (Address) *Franklin Sq. Nos.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *8* mos. *8* ds. In the *22* yrs. mos. ds.Where was disease contracted, if not at place of death? *at home*Former or usual residence *401 Vincent alley*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*St. Auburn**Sept 23, 1915*

20-UNDERTAKER

ADDRESS *306 N.**Hill & Brown Mount St.*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2210 Lynbrook Ave St. 13 WARD)

2-FULL NAME

Charles S. Knell

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2210 Lynbrook Ave St. 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Married

6-DATE OF BIRTH

Sept
(Month)21 1875
(Day) (Year)

7-AGE

40 yrs. mos. ds. or min.?If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Book-keeper9-BIRTHPLACE
(State or country)Baltimore Md

10-NAME OF FATHER

John Knell11-BIRTHPLACE OF FATHER
(State or country)Balto. Md

12-MAIDEN NAME OF MOTHER

Elmer Danner13-BIRTHPLACE OF MOTHER
(State or country)Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Catherine Knell

(Address)

2210 Lynbrook Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept
(Month)21
(Day)1915
(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 20, 1915, to, Sept 20, 1915,that I saw him alive on Sept 20, 1915,
and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) 9 yrs. mos. ds.Contributory
(SECONDARY)

(Signed)

William Hart

M. D.

Sept 21, 1915 [Address] 2731 Parkwood

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cathedral Cem.

DATE OF BURIAL

Sept 24, 1915

20-UNDERTAKER

Harry W. Ehlert

ADDRESS

1944 W. North AveSEP 23 1915
Filed 1915HARRY O. ANDREWS,
Bureau Permit Clerk
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88365

C88365

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 BrumeST. 16

WARD)

REGISTERED NO. C

2-FULL NAME Jane Wohlfauth

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 713 Brume STSt.; Lifton yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

August

(Month)

2

(Day)

1861

(Year)

7-AGE,

54yrs. 1 mos. 20 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Eliza McPherson

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

Elizabeth & Rose

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. W. Pendleton(Address) 725 Harlem Ave

15-

SEP 23 1915

Filed:....., 191.....

HARRY O. SANDERS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

(Month)

22

(Day)

1915

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

March1915, to Sept 22

1915,

that I saw h L alive on Sept 21

1915,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritisin late stage

CONTRIBUTORY (Secondary)

in late stage

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

Sept 24, 1915.

20-UNDERTAKER

H. B. Manning & Son

ADDRESS

317 N. Schroeder St

C88366

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88366

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 N Bond ST. 6 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 418 N. Bond St. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov 4, 1854
(Month) (Day) (Year)

7-AGE, 60 yrs. 9 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Plumber

9-BIRTHPLACE, (State or Country),

City

10-NAME OF FATHER,

Christopher Baer

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Margaret

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edward Baer

(Address)

418 N. Bond

15-

SEP 23 1915

Filed

191

MORTALITY BUREAU

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 21, 1915.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 21, 1915, to Sept 21, 1915, that I saw him alive on Sept 21, 1915, and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows:

Uræmia (Uræmic Convulsions)(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

Nephritis

(Duration) yrs. mos. ds.

(Signed) Elyse L. Russell, M. D.Sept 22, 1915, (Address) 423 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

McBarnetSept 24, 1915

20-UNDERTAKER

ADDRESS

Philip Herwig2016 Orleans

(88367)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Mercy Hospital* ST.: *19* WARD)

FULL NAME

(Residence in Baltimore: No. *1714 W. Gouldland St.*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *75* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male.

4-COLOR OR RACE,

*White*5-STATUS.
MARRIED, *Married*
WIDOWER,
OR DIVORCED,
(Write the word)

6-DATE OF BIRTH,

April 12, 1890
(Month) (Day) (Year)

7-AGE,

25 yrs. *5* mos. *9* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Book*
Yard Clerk R.R.

9-BIRTHPLACE,

(State or Country),

City

10-NAME OF FATHER,

George Kraft

11-BIRTHPLACE OF FATHER (State or Country),

City

12-MAIDEN NAME OF MOTHER

Amelia Selmer

13-BIRTHPLACE OF MOTHER (State or Country),

City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Agnes Surian*(Address) *1714 W. Gouldland St.*

15-

Filed

SEP 23 1915

HARRY O. ANDERSON,

191 Marial. Parmit. Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 21, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*
(Inquest, autopsy or inquiry.)*Inquest* and that said deceased came to *his* death
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH was as follows:

Accident - R.R. fell off of
freight car & ran over by car.
(Duration) *for minutes* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) *H. H. Chambers* M. D.
(Coroner.)
Sept. 21 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. *for months* mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?...

Former or usual residence *1714 W. Gouldland St.*

19-PLACE OF BURIAL OR REMOVAL,

Western Ave.

DATE OF BURIAL,

Sept 24, 1915

20-UNDERTAKER

Josh Cook

ADDRESS

1003 N. Calto.

C88368

HEALTH DEPARTMENT-CITY OF BALTIMORE

C88368

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1152 N. Stricker St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Edith M. Whiteside

(Residence in Baltimore: No. 1152 N. Stricker St. 31 yrs. 10 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

Oct 20, 1883

(Month)

(Day)

(Year)

7-AGE

31 yrs. 10 mos. 27 ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Seamstress

9-BIRTHPLACE
(State or country)

Baltimore, Md.

10-NAME OF FATHER

Samuel Whiteside

PARENTS

11-BIRTHPLACE OF FATHER
(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Sarah E. Crist

13-BIRTHPLACE OF MOTHER
(State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel Whiteside

(Address)

1152 N. Stricker

15

SEP 23 1915

HARRY O. ANDREWS,

Baltimore, Md. Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 22, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1915, to Sept. 22, 1915, that I saw him alive on Sept. 22, 1915, and that death occurred, on the date stated above, at 1:05 p.m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory
(SECONDARY)

(Duration) 1 yrs. 10 mos. 27 ds.

Exhaustion, Cardiac Asthenia

(Signed)

G. A. Thiede M. D.

Sept 22, 1915 (Address) 1135 N. Lawrence

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park Cemetery

DATE OF BURIAL

Sept 25, 1915

20-UNDERTAKER

Joseph T. Cook -

ADDRESS

1103 West Baltimore St.

Very important. See instructions on back of certificate.

C88369

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88369

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

Mary Hospital

ST.:

WARD)

2-FULL NAME

John S. Kaidel

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

(Residence in Baltimore: No.

2112 Wilkes Ave

St.; yrs., 30 mos. dw.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

July

6

1875

(Month)

(Day)

(Year)

7-AGE,

40

yrs.

2

mos.

15

da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Conductor. R.R.

9-BIRTHPLACE,
(State or Country),

N. J.

10-NAME OF FATHER,

Kaidel

11-BIRTHPLACE OF FATHER
(State or Country),

N. J.

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER
(State or Country),

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Jennie Kaidel

(Address)

2112 Wilkes Ave

15-

SEP 23 1915

HARRY C. ANDREWS

191

BALTIMORE

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September

21

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest
(Inquest, au-inquest and that said deceased came to his death
(Inquest, au-
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident. R.R. Fell off of freight
car & ran over by rail(Duration) few minutes yrs. mos. da.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) Pho. R. Chambers M. D.Sept 22 1915 (Address) 18. St. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. few minutes in the State... yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

London Park Cem

DATE OF BURIAL,

SEP 23 1915

20-UNDERTAKER

Geo W. Gerbig

ADDRESS

Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88370

CERTIFICATE OF DEATH.

92 C88370
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

917 Boyd

ST.: 18

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

George Brown

(Residence in Baltimore: No.

917 Boyd

St.;

Life

mos.

yrs.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

colored

5-SINGLE,

MARRIED, single
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

March 4, 1873
(Month) (Day) (Year)

7-AGE,

42 yrs. 6 mos. 17 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

General

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

John Brown

11-BIRTHPLACE OF FATHER

(State or Country),

Balto, Md.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Nancy Gray

(Address).....

917 Boyd St

15-

SEP 23 1915

HARRY O. ANDREWS,

Filed.....

191..

Baltimore, Md.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 21, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 20 1915, to Sept 21 1915,

that I saw him alive on Sept. 20 1915,

and that death occurred, on the date stated above, at 7:05 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....

(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....Chester Riland.....M. D.

9-21-1915 (Address) 2532 Edmondson St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSFERS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Auburn

DATE OF BURIAL,

Sept. 21, 1915

20-UNDERTAKER

John H. Swan & Son

ADDRESS

901 Hollis St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88371

CERTIFICATE OF DEATH.

28 C88371
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1545 Leslie ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Marshall Dorsey

(Residence in Baltimore: No. 1545 Leslie

St.; 18 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH,

June 9, 1877
(Month) (Day) (Year)

7-AGE,

38 yrs. 3 mos. 13 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Laborer
farm-hand9-BIRTHPLACE,
(State or Country),

Carroll County, Md.

10-NAME OF FATHER,

Eugene D. Dorsey

11-BIRTHPLACE OF FATHER
(State or Country),

Carroll County, Md.

12-MAIDEN NAME OF MOTHER

Annie M. Cato

13-BIRTHPLACE OF MOTHER
(State or Country),

Carroll County, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant):

Martha Roberts

(Address):

1545 Leslie St.

15-

SEP 23 1915

Filed..... 191. MAR 11 1916

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 11 1915, to Sept. 22 1915, that I saw him alive on Sept. 21 1915, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 2 yrs. 2 mos. 13 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. E. Clark M. D.

Sept. 22 1915 (Address) 1310 N. E. 10th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

The Lutheran Church

DATE OF BURIAL,

Sept. 25 1915

20-UNDERTAKER

John H. Owens

ADDRESS

1222 W. 10th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88372

C88372

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104)Johns Hopkins Hosp.8

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

Margaret Luker(Residence in Baltimore: No. 1533 Hakesley PlaceSt.; yrs. 3 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

June 20th1915

(Month)

(Day)

(Year)

7-AGE,

3 yrs. 2 mos. 2 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

Hermann Abden11-BIRTHPLACE OF FATHER
(State or Country),Baltimore

12-MAIDEN NAME OF MOTHER

Theresa Luker13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....P. Troop(Address).....Johns Hopkins Hospital

15-

Filed.....

SEP 23 1915

191.....

HARRY O. ANDERSONJOHN P. PATRICK OLOFF

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

November 22nd1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 16th 1915, to Sept. 22nd 1915, that I saw her alive on Sept 22nd 1915, and that death occurred, on the date stated above, at 4:21 P. M.

The CAUSE OF DEATH* was as follows:

Alimentary Intoxication(Duration).....yrs.....mos..21 ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....L. J. Power.....M. D.Sept. 23rd, 1915. (Address).....Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos..6 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

1533 Hakesley Place

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy RosarySept. 27th, 1915

20-UNDERTAKER

ADDRESS

A. Pink215 N. Gay

C88373

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88373

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1500 E. Baltimore St.* ST.; *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1500 E. Baltimore St.* St.; *50* yrs., *6* mos. *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

April 12, *1865*
(Month) (Day) (Year)

7-AGE,

50 yrs., *6* mos., *12* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*At home*

9-BIRTHPLACE, (State or Country),

Baltimore Md.

10-NAME OF FATHER,

John H. Nagel

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Dorothy Wirth

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Fred Nagel*(Address) *1500 E. Baltimore St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 22nd, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 4th 1915, to *Sept 22nd* 1915,that I saw him alive on *Sept 22nd* 1915,and that death occurred, on the date stated above, at *9:15 P.* m.

The CAUSE OF DEATH* was as follows:

Aortic and Mitral Regurg.
Myocarditis Chronic(Duration) *7* yrs., *7* mos., *7* ds.

CONTRIBUTORY (Secondary)

Enlarged heart(Duration) *1* yr., *7* mos., *7* ds.(Signed) *A. F. Rice* M. D.*Sept. 22nd*, 1915. (Address) *24 E. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospital, Institutional Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Carmel

DATE OF BURIAL,

Sept. 25th, 1915.

20-UNDERTAKER

Louis Heermann

ADDRESS

32 E. Broadway

15-

Filed *SEP 23 1915* *HARRY C. ANDERSON* Registrar.

C88374

HEALTH DEPARTMENT-CITY OF BALTIMORE

C88374

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No.

St.: 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

colored

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

Unknown, 1860

7-AGE

55

yrs.

mos.

ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

Virginia

10-NAME OF FATHER

George Adams

11-BIRTHPLACE OF FATHER
(State or country)

Virginia

12-MAIDEN NAME OF MOTHER

Catherine Suede

13-BIRTHPLACE OF MOTHER
(State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mary M. Sanders

(Address)

914 N. Eutaw St.

15

SEP 23 1915

FRI

HARRY C. ANDREWS

Special Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept

21, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 14, 1915, to, Sept 21, 1915,

that I saw him alive on Sept 21, 1915,

and that death occurred, on the date stated above, at 2:40 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration)

yrs.

mos.

ds.

Contributory
(SECONDARY)

Stroke

(Duration)

yrs.

mos.

ds.

(Signed),

Charles H. Henshaw

M. D.

Sept 2, 1915 (Address) 714 S. Deane St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Lexington, Virginia

DATE OF BURIAL

Sept 25, 1915

20-UNDERTAKER

Wes. A. Holland

ADDRESS

517 Robert St.

Very important. See instructions on back of certificate.

C88375 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *324 S. Calhoun* ST. *19* WARD)

2-FULL NAME *Annie E. Rieman*

(Residence in Baltimore: No. *324 S. Calhoun*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *Life* mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow* (Write the word.)

6-DATE OF BIRTH, *Jan 9th*, 18*56* (Month) (Day) (Year)

7-AGE, *59* yrs. *6* mos. *13* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *None* (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Md. Balto.*

10-NAME OF FATHER, *Remley*

11-BIRTHPLACE OF FATHER (State or Country), *Md.*

12-MAIDEN NAME OF MOTHER *Ellen Gardner*

13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Carrie Richler*

(Address) *324 S. Calhoun*

15-SEP 23 1915 ROBERT KRAUTER REGISTRAR

Filed....., 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 22nd*, 191*5* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry) find that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Signed) *Samuel H. M. D.* (Coroner)

Sept. 23, 1915 (Address) *2302 Madison Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Louisa Park*

DATE OF BURIAL, *Sept. 24 1915*

20-UNDERTAKER, *William Cook*

ADDRESS *542 E. North Ave.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88376

CERTIFICATE OF DEATH.

151 C88376

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Vincent's Infy Asy. St.* 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St Vincent's Infant Asylum St.* yrs., 1 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED, *Single*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

August 3rd, 1915
(Month) (Day) (Year)

7-AGE,

1 mos. 18 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business, or establishment in which
employed (or employer)*None*9-BIRTHPLACE,
(State or Country),*Maryland Balto.*10-NAME OF
FATHER,*Unknown*11-BIRTHPLACE
OF FATHER
(State or Country),*Unknown*12-MAIDEN NAME
OF MOTHER*Unknown*13-BIRTHPLACE
OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St Vincent's*(Address) *1401 Division St.*

15-

Filed

SEP 23 1915

101

ROBERT

KRAUTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 22, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Sept 1st 1915, to Sept 21 1915*that I saw him alive on *Sept. 21 1915*and that death occurred, on the date stated above, at *1:30 p.m.*

The CAUSE OF DEATH* was as follows:

*Malnutrition and
Malassimilation*
(Duration) *7 mos.* ds.CONTRIBUTORY
(Secondary)(Duration) *7 yrs.* mos. ds.(Signed) *John J. Farley* M. D.*Sept. 22, 1915. (Address) 1223 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *15* ds. In the State yrs. *1* mos. *18* ds.Where was disease contracted,
if not at place of death?Former or usual residence *St Vincent's Infy Asylum*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Sep 23 1915

20-UNDERTAKER

ADDRESS

M. Farley & Sons 624 Fayette St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *92*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Schneider Frank* St.; *7* yrs., *7* mos., *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

2 *8*, 1915
(Month) (Day) (Year)

7-AGE,

7 yrs., *7* mos., *15* ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

None

9-BIRTHPLACE, (State or Country),

Balt. Md.

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. G. Schetter*(Address) *216 E. 1st St.*

15-

Filed

SEP 23 1915

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept *23*, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Feb. 25*, 1915, to *Sept 23*, 1915, that I saw him alive on *Sept 22*, 1915, and that death occurred, on the date stated above, at *1 A.* m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Edgar B. Kennedy* M. D.

Sept 23, 1915 (Address) *1616 Linden Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *7* mos. ds. In the State yrs. *7* mos. *15* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cem.

DATE OF BURIAL,

Sept 24, 1915

20-UNDERTAKER

George J. Smith

ADDRESS

1616 Linden Ave.

C88378

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88378

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 1704 W. Fayette St. 19

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Joseph Henry Fullen

(Residence in Baltimore: No. 1704 W. Fayette St. 30 yrs. 8 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-MARRIED

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

unmarried

6-DATE OF BIRTH

Jan 1, 1885

(Month)

(Day)

(Year)

7-AGE

30

8

22

If LESS than 1 day, hrs., or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment which employed (or employer)

Caf Tel Co

9-BIRTHPLACE

(State or country)

Baltimore Md

10-NAME OF FATHER

John J. Fullen

11-BIRTHPLACE OF FATHER (State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Margaret Gorky

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Leonard Fullen

(Address)

1704 W. Fayette St.

15-

SEP 23 1915

HUBERT

KRAUTER

MILK REPAIR CLERK

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept

23, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from Jan 9th, 1915, to, Sept 23, 1915, that I saw him alive on Sept 21st, 1915, and that death occurred, on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)

yrs.

mos.

ds.

Contributory (SECONDARY)

Tubercular Enteritis

(Duration)

yrs.

mos.

ds.

(Signed)

William J. Messick M. D.

Sept 23, 1915

[Address]

1700 Linden Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

New Baltimore

DATE OF BURIAL

Sept 27, 1915

20-UNDERTAKER

George J. Smith

ADDRESS

Fayette St.

HEALTH DEPARTMENT-CITY OF BALTIMORE

C88379

CERTIFICATE OF DEATH

C88379

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *Hebrew Hospital*)ST: *2* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Solomon Raskin*(Residence in Baltimore: No. *1921 E. Pratt*)St.: yrs. *7* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Child*
(Write the word)6 DATE OF BIRTH *March 24, 1915*
(Month) (Day) (Year)7 AGE *7* yrs. *7* mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*none*

9 BIRTHPLACE (State or country)

Balt Md

10 NAME OF FATHER

Louis Raskin

11 BIRTHPLACE OF FATHER (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Sarah Magareck

13 BIRTHPLACE OF MOTHER (State or country)

Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Lewis

(Address)

1419 E. Pratt St

15 SEP 23 1915

Filed

191

J. KRAUTER

BIRTHAL Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

September 22, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from

*July 15, 1915, to, Sept 22, 1915,*that I saw him alive on *Sept. 22, 1915,*and that death occurred, on the date stated above, at *8:45 p. m.*

The CAUSE OF DEATH* was as follows:

Marasmus

Contributory (SECONDARY)

(Duration) yrs. *3* mos. ds.*Neocolitis*

(Signed)

M. B. Lewis

M. D.

Sept 22, 1915 (Address) *Hebrew Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. *2* mos. *7* ds. In the State yrs. *7* mos. ds.

Where was disease contracted,

If not at place of death?

Home

Former or

usual residence

1921 E. Pratt St.

19 PLACE OF BURIAL OR REMOVAL

Hebrew Hospital

DATE OF BURIAL

9/23, 1915

20 UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Pratt St

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

7-AGE,

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

15-

Filed

SEP 23 1915

191

ROBERT KRAUTH
Baltimore
Registrar.M. Curfman
Baltimore

264 N. Main

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88381

CERTIFICATE OF DEATH.

126

C88381

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *21* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Henry Kraemer*(Residence in Baltimore: No. *1571 Ridgely* St.; *73* yrs., *7* mo., *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

*Feb**20th**1842*

(Month)

(Day)

(Year)

7-AGE.

*73**7**2*

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Merchant
Grocery

9-BIRTHPLACE, (State or Country).

Maryland Balto

PARENTS.

10-NAME OF FATHER.

Frederick Kraemer

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER.

Amelia Altmeppen

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Kraemer*(Address) *1571 Ridgely St.*

15-

SEP 23 1915

Filed

191

ROBERT . KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 22, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 30, 1915 to *Sept 22, 1915*that I saw him alive on *Sept 22, 1915*and that death occurred, on the date stated above, at *5:10 P.M.*

The CAUSE OF DEATH* was as follows:

Myocardial Infarct(Duration) *77* yrs. *7* mo. *2* ds.

CONTRIBUTORY (Secondary)

Post-operative Pneumonia(Duration) *2* ds.(Signed) *Elmer J. Williams, M.D.**Sept 22, 1915* (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *22* ds. In the *73* yrs. *7* mo. *2* ds. State

Where was disease contracted, if not at place of death?

Former or usual residence *1571 Ridgely St.*

19-PLACE OF BURIAL OR REMOVAL.

Louisa Park

DATE OF BURIAL.

Sept 24, 1915

20-UNDERTAKER

J. B. Cook

ADDRESS

1003 N. E. St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (NO.

ST.

WARD)

2-FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No.

St.; 2 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

(Month)

(Day)

(Year)

7-AGE

If LESS than

1 day, hrs.

1.34

yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (for employer)9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

PARENTS

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

SEP 23 1915

ROBERT KRAUTER,
Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 20, 1915, to, Sept 22, 1915,

that I saw him alive on Sept 20, 1915,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart
Mitral Regurgitation
Dilated HeartContributory
(SECONDARY)

(Signed)

Sept 22, 1915 [Address] 739 W. Fayette

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Josephs Hospital* ST. *9* WARD)

2-FULL NAME

Frederick W. G. Vogel

(Residence in Baltimore: No. *1572 N. Springs*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. *from birth* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH,

Sept.

2nd

1898

7-AGE

20

19

ds.

It LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9-BIRTHPLACE.

(State or Country),

Galts, Md.

10-NAME OF FATHER,

Wm. Vogel

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Minnie L. Meyer

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Minnie Vogel

(Address)...

1572 N. Springs

15-

ROBERT KRAUTER,

SEP 23 1915 *Funeral Permit Clerk*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept.

27th

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to his death *on the day stated above.*

The CAUSE OF DEATH* was as follows:

Ruptured liver and internal hemorrhage, the result of the motor cycle on which he was riding accidentally striking a telegraph post.

CONTRIBUTORY (Secondary)

(Duration).... yrs.... mos.... ds.

(Signed) *Wm. M. Savage* M. D.

Sept. 23, 1915 (Address) *1729 W. Madison St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs.... mos.... ds. State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?....

In Harbor Road

Former or usual residence *1572 N. Springs St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Trinity Cemetery

Sept. 24 1915

20-UNDERTAKER

ADDRESS

Henry Lutz 1007 N. Bond St.

888384

HEALTH DEPARTMENT-CITY OF BALTIMORE

888384

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1509 N. Durham St. WARD)

2 FULL NAME

(Residence in Baltimore: No. 1509 N. Durham St. 5 years ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

SEP 24 1915

HARRY O. ANDERSON,

Filed

191

Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

June 15, 1915, to Sept. 22, 1915.

that I saw her alive on Sept. 20, 1915,

and that death occurred, on the date stated above, at 1:04 p.m.

The CAUSE OF DEATH* was as follows:

Marasmus (Febrile tuberculosis)

(Duration) yrs. 5 mos. ds.

Contributory (SECONDARY)

(Duration) yrs. 1 mos. ds.

(Signed) H. H. Singmaster, M. D.

Sept. 23, 1915. (Address) 1509 N. Durham St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Robt. Schmitt 1442 N. Spring

C88385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life time ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

6-DATE OF BIRTH,

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry.) And that said deceased came to her death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Fracture base of skull, the result of accidentally of walking off a moving street car.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Moses M. Savage M. D.

(Coroner.)

Sept 23, 1915 (Address) 1729 Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs... mos... ds. In the State of... yrs... mos... ds.

Where was disease contracted, if not at place of death?.....

On north av. near Creel St.

Former or usual residence 1410 N. Chester St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery

Sept 26, 1915

20-UNDERTAKER

ADDRESS

George Schilling & Sons

1126 E. Monument St.

SEP 24 1915

FIVE

1915

J. G. HARRY & SONS

BALTIMORE POPULATION

HEALTH DEPARTMENT—CITY OF BALTIMORE

88386

CERTIFICATE OF DEATH.

91 88386
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 Brodway ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Connolly

(Residence in Baltimore: No. 717 Brodway St.; 2 yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 21, 1913

(Month)

(Day)

(Year)

7-AGE, 2 yrs., mos. 2 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Wm Connolly

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Sarah Banister

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry O. Andrews

(Address) 520 Brodway

15-SEP 24 1915

FRI

HARRY O. ANDREWS,

Sanial Form 10-10-13

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep 23, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from Sep 22, 1915, 9.22. 1915, that I saw her alive on Sep 22, 1915, and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Branch pneumonia
maroon (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) L. L. Lenz M. D.
9.23, 1915. (Address) 639 2nd Avenue

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Sep 24, 1915

20-UNDERTAKER, Samuel T. Kearsley

ADDRESS, 578 W. Biddle

is very important. See instructions on back of certificate.

Exact statement of OCCUPATION

17
1103

SEP 24 1915

HARRY O. ANDREWS,
Serial Permit Clerk.
REGISTRAR

C88387

HEALTH DEPARTMENT--CITY OF BALTIMORE CERTIFICATE OF DEATH

108

C88387

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Hebrew Hospital*)

2-FULL NAME

Anna Stein

(Residence in Baltimore: No. *301 N. Carrollton Ave*)

REGISTERED NO. C

ST. *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *88* yrs. *3* mos. *ds.*

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

Unknown, 1

7-AGE

59

(Month)

(Day)

(Year)

If LESS than
1 day, --- hrs.
or --- min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE
(State or country)

Russia

10-NAME OF FATHER

Ellen Anderson

11-BIRTHPLACE OF FATHER
(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Bessie Lester

13-BIRTHPLACE OF MOTHER
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. Stein

(Address)

301 N. Carrollton Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept

(Month)

24

(Day)

1915

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 23*, 1915, to *Sept 24*, 1915, that I saw he alive on *Sept 24*, 1915, and that death occurred, on the date stated above, at *3. a* m. The CAUSE OF DEATH* was as follows:

*Cerebral - Ruptured
appending*

Contributory
(SECONDARY)

Pulmonary edema

(Signed),

Sept 24

, 1915

M. B. Leary

(Address)

Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

--- yrs. --- mos. --- ds.

In the

State

--- yrs. --- mos. --- ds.

Where was disease contracted, if not at place of death?

Former or usual residence

301 Carrollton Ave

19-PLACE OF BURIAL OR REMOVAL

20-UNDERTAKER

Hebrew Hospital
S. Stein
Bro E Balto

DATE OF BURIAL

ADDRESS

C88388

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88388

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2521 Foster Ave. St.; 1 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2521 Foster Ave. St.; 50 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widowed
(Write the word.)6-DATE OF BIRTH, Aug. 25, 1881
(Month) (Day) (Year)7-AGE, 84 yrs., 29 mos., da. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer). Cobbler9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, Not Known11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER, Not Known13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Sanders(Address) 2521 Foster Ave.

15-SEP 24 1915

Filed....., 191.....

HARRY O. ANDERSON,

Married Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 23, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1915, to Sept. 23, 1915, that I saw him alive on Sept. 23, 1915, and that death occurred, on the date stated above, at 6:40 P.

The CAUSE OF DEATH* was as follows:

Stone in Bladder
Chronic Interstitial Nephritis
(Duration) 6 yrs., 6 mos., da.CONTRIBUTORY (Secondary) old age(Duration) yrs., mos., da.(Signed) J. Albert Miller, M. D.9/23/1915 (Address) 2521 Foster Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., da. In the State yrs., mos., da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Schwartz Family Sept. 25, 1915

20-UNDERTAKER

ADDRESS BaltimoreJohn A. Mann & Co.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME *Augustus Duffins*(Residence in Baltimore: No. *1385 Whitcomb Street* St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE

*colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

*July**2**1915*

(Month)

(Day)

(Year)

7-AGE,

*24*yrs. *2* mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

md.

10-NAME OF FATHER,

Arthur Duffins

11-BIRTHPLACE OF FATHER (State or Country),

md.

12-MAIDEN NAME OF MOTHER

Maudie Duckett

13-BIRTHPLACE OF MOTHER (State or Country),

md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. J. Smith*(Address) *Johns Hopkins Hospital*

15 SEP 24 1915

HARRY O. ANDREWS,

Filed..... 191

Serial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*September**19**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 17 191*5*, to *Sept. 19* 191*5*,that I saw him alive on *September 19* 191*5*,and that death occurred, on the date stated above, at *3:55 a. m.*

The CAUSE OF DEATH* was as follows:

Alimentary Intoxication(Duration) *2* yrs. *2* mos. ds.

CONTRIBUTORY (Secondary)

(Duration) *4* yrs. *4* mos. ds.(Signed) *A. J. Powers* M. D.*Sept. 19*, 191*5*. (Address) *Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. *2* yrs. *2* mos. ds. In the State *2* yrs. *2* mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1385 Whitcomb Street*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Per. Wm. E. WOODALL

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88390

C88390

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *7* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1502 Mc Elderry* St.: *7* yrs., *7* mos., *1* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

Unknown
(Month) (Day) (Year)

7-AGE.

4 yrs., *7* mos., *1* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE, (State or Country),

md

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP 24 1915

Filed

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

September 21, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Sept. 20, 1915 to *Sept 20, 1915*that I saw her alive on *Sept 20, 1915*and that death occurred, on the date stated above, at *8:40 p.m.*

The CAUSE OF DEATH* was as follows:

Intoxication, alimentary

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

pneumonia (Duration).....yrs.....mos.....ds.(Signed) *J. F. Powers**Sept 21, 1915* (Address) *Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. in the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

1502 Mc Elderry St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Asbury Cemetery *Sept 24, 1915*

20-UNDERTAKER

ADDRESS

R. B. Gross 1405 Mc Elderry St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Bruce St. St.; 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Francis(Residence in Baltimore: No. 1003 Bruce St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male4-COLOR OR RACE. black5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, Sept. 22, 1915
(Month) (Day) (Year)7-AGE,
yrs. mos. ds.If LESS than 1 day,
....hrs. or 13 min.

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
-
- (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country), Maryland10-NAME OF FATHER, Henry D. Francis11-BIRTHPLACE OF FATHER
(State or Country), Maryland12-MAIDEN NAME OF MOTHER Mary Francis13-BIRTHPLACE OF MOTHER
(State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas H. Eakin, M.D.(Address) Mary Hospital

15-

SEP 24 1915

HARRY U. ANDREWS,

Serial Peralt Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1915, to Sept 22 1915, that I saw him alive on Sept 22 1915, and that death occurred, on the date stated above, at 11:57 am.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Edward P. Smith M. D.(Address) Mary Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,
COLLEGE OF P. & S.DATE OF BURIAL,
SEP 24 1915

Underwriter Health,

ADDRESS

Per. Wm E. WOODALL.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88392

CERTIFICATE OF DEATH.

154 C88392

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

110 N Bradford

ST.;

REGISTERED NO. C

WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John Ellis

(Residence in Baltimore: No.

110 N Bradford

St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH,

May

1840

(Month)

(Day)

(Year)

7-AGE,

75

4

mos.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Carpenter

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Not Known

11-BIRTHPLACE OF FATHER (State or Country),

Not Known

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER (State or Country),

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Geo Hetzler

(Address)

110 N Bradford St

15-

Filed

SEP 24 1915

HARRY O. ANDRAUS,

Serial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

23

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1915, to Sept 23, 1915,

that I saw him alive on Sept 10, 1915,

and that death occurred, on the date stated above, at 1-2-2 St.

The CAUSE OF DEATH* was as follows:

Breast - due to old age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. Valentine, M. D.

Sept 23, 1915 (Address) 16 So Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore

DATE OF BURIAL,

Sept 24, 1915

20-UNDERTAKER

Peter Nicolaus

ADDRESS

2046 Eastern Ave

C88393

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 C88393
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *Mary Hospital* ST. *12* WARD)

2-FULL NAME

Asa Needham Jr.
(Residence in Baltimore: No. *423-E-22nd W* St.; yrs. mos. *3* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)6-DATE OF BIRTH, *Sept 20, 1885*
(Month) (Day) (Year)7-AGE, *3* If LESS than 1 day, yrs. mos. da. hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *City*10-NAME OF FATHER, *Asa Needham*11-BIRTHPLACE OF FATHER (State or Country), *City*12-MAIDEN NAME OF MOTHER, *Mary E. Jackson*13-BIRTHPLACE OF MOTHER (State or Country), *City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Asa Needham*(Address) *423-E-22nd W*

15-SEP 24 1915 HARRY O. ANDREWS,

Filed....., 191... *Surial Permit Clerk* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 23, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 20* 1915, to *Sept 23* 1915, that I saw him alive on *Sept 23* 1915, and that death occurred, on the date stated above, at *5:30* m.

The CAUSE OF DEATH* was as follows:

Branch pneumonia
(Duration) yrs. mos. ds.CONTRIBUTORY *Aspiration of mucus*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Ernie Novak* M. D.*Sept 23, 1915* (Address) *Mary Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *Mary Hospital*Former or usual residence *Mary Hospital*19-PLACE OF BURIAL OR REMOVAL, *Brown Mt* DATE OF BURIAL, *Sept 24, 1915*20-UNDERTAKER, *W. J. Johnson* ADDRESS, *Novak*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Euter Hall, Mountbello Ave.* ST. *9* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John Chalmer*(Residence in Baltimore: No. *Euter Hall, Mountbello Ave.* St. *10* yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)

6-DATE OF BIRTH.

May 20, *1838*
(Month) (Day) (Year)

7-AGE,

77 yrs. *4* mos. *7* da.If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Land business

9-BIRTHPLACE,

(State or Country).

Scotland

10-NAME OF FATHER,

Don't Know

11-BIRTHPLACE OF FATHER

(State or Country)

Scotland

12-MAIDEN NAME OF MOTHER

Don't Know

13-BIRTHPLACE OF MOTHER

(State or Country).

Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary A. Chalmer*(Address) *Euter Hall, Mountbello Ave.*

15-

SEP 25 1915

Filed

ROBERT K. KRAUTER,

Morial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept, *23*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug. 26*, *1915*, to *Sept 23*, *1915*, that I saw him alive on *Sept 22*, *1915*, and that death occurred, on the date stated above, at *4:20* a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia with abscess and gangrene of the lung
(Duration) *2* yrs. *7* mos. *28* da.

CONTRIBUTORY (Secondary)

Age Exhaustion
(Duration) *7* yrs. *7* mos. *7* da.(Signed) *William J. Pillsbury* M. D.*Sept 23*, *1915* (Address) *2801 York Rd*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs. *7* mos. *28* da. In the State *2* yrs. *7* mos. *28* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Gruid Ridge Cem *Sept 25*, *1915*

20-UNDERTAKER

ADDRESS

Wm Cook *5015 Mt Airy*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88395

104 C88395

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2306 Cambridge St.; 1 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 2306 Cambridge St.; 1 yrs., 7 mos., 7 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Single

6-DATE OF BIRTH.

Sept. 17, 1914
(Month) (Day) (Year)

7-AGE,

1 yrs., 9 mos., 9 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None
Infant9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

Benedict Blaszak11-BIRTHPLACE OF FATHER
(State or Country),Russian Poland

12-MAIDEN NAME OF MOTHER

Mary Orlovsk13-BIRTHPLACE OF MOTHER
(State or Country),Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benedict Blaszak(Address) 2306 Cambridge St.

15-

SEP 25 1915

ROBERT KRAUTER,

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 23, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Sept. 16, 1915, to Sept 23, 1915,that I saw her alive on Sept 23, 1915,and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis(Duration) Ca 14 ds.CONTRIBUTORY
(Secondary)Bronchitis(Duration) 1 wk.(Signed) J. J. Larusson M. D.(Address) 2431 Fair Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 1 yrs., 9 mos., 9 ds. In the State 1 yrs., 9 mos., 9 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Sept 25, 1915

20-UNDERTAKER

William Gialowski

ADDRESS

1618 Eastern Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88396

CERTIFICATE OF DEATH.

67 C88396

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *306 Federal*)ST.; *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James Henderson Green*(Residence in Baltimore: No. *306 Federal*)St.; *30* yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)

6-DATE OF BIRTH, *Nov. 23*, *1863*
(Month) (Day) (Year)

7-AGE, *51 yrs. 10 mos. 0 ds.* If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Traveling Auditor*
(b) General nature of industry, business, or establishment in which employed (or employer), *B. W. R. R.*

9-BIRTHPLACE, (State or Country), *Calif. Va.*

10-NAME OF FATHER, *James E. Green*
11-BIRTHPLACE OF FATHER, (State or Country), *Calif. Va.*
12-MAIDEN NAME OF MOTHER, *Anna A. Harris*
13-BIRTHPLACE OF MOTHER, (State or Country), *Calif. Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Morris L. Green*(Address) *306 Federal St.*

15- SEP 25 1915
MURBERT KRAUTER,
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 23rd*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *about Jan* 1911, to *Sept 23rd* 1915, that I saw him alive on *Sept 23rd* 1915, and that death occurred, on the date stated above, at *10 A. m.*

The CAUSE OF DEATH* was as follows:

Paresis
(Duration) *about 4 yrs.*

CONTRIBUTORY (Secondary)

(Duration) *4 yrs.* (Signed) *Henry F. Hill* M. D.
Sept. 24th 1915 (Address) *1001 E. Madison Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cathedral Cemetery*DATE OF BURIAL, *Sept. 25, 1915*

20-UNDERTAKER, *Henry W. Hill & Son*
Address *805 N. Calvert St.*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and full apt No. 10.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.,

or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 21, 1915, to Sept 23, 1915,

that I saw him alive on Sept 23, 1915,

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Duration)

yrs

mos.

ds.

(Signed)

M. D.

9/23/15

[Address]

1815 N. Charles St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-SIGNATURE

ADDRESS

18-

SEP 25 1915

ROBERT . BRAUTER,
Serial Permit Clerk
REGISTRAR

9 a.m.

St. Vincent & Sept 25, 1915
St. Mary's Hall 3539 7th Ref

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88398

C88398

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *3531 Falls Rd* ST. *13* WARD)2-FULL NAME *Florence E. Brooks*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RM out No. 18.)

(Residence in Baltimore: No. *3531 Falls Rd* St.; *40* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE MARRIED *Married* WIDOWED OR DIVORCED (Write the word)6-DATE OF BIRTH *June 6, 1872* (Month) (Day) (Year)7-AGE *43* yrs. *3* mos. *18* ds. or min. 2 If LESS than 1 day, hrs.8-OCCUPATION (a) Trade, profession or particular kind of work *House Wife* (b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE (State or country) *Balt Co Md*10-NAME OF FATHER *John B. Peters*11-BIRTHPLACE OF FATHER (State or country) *Germany*12-MAIDEN NAME OF MOTHER *Anne E. Cole*13-BIRTHPLACE OF MOTHER (State or country) *Balt Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Norrie Brooks*(Address) *3531 Falls Rd*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept 24, 1915* (Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from *May 1st*, 1915, to, *Sept 24*, 1915, that I saw him alive on *Sept 23*, 1915, and that death occurred, on the date stated above, at *9:30 a m.*

The CAUSE OF DEATH* was as follows:

Endocarditis(Duration) yrs. *5* mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) *M. A. Fair* M. D.*Sept 24, 1915* [Address] *12 E 20th*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *St Mary's N* DATE OF BURIAL *Sept 26 1915*ADDRESS *A S Marshall 3539 Falls Rd*

18- SEP 25 1915

ROBERT J. KRAUTER

Marital Permit Clerk

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88399

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hospital* ST. *9* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

2-FULL NAME

(Residence in Baltimore: No. *St. Josephs Hospital* St.; yrs. mon. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

unknown, 1 (Month) (Day) (Year)

7-AGE,

21 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Balto Co. Md.

PARENTS.

10-NAME OF FATHER,

Stephen L. Gloyd

11-BIRTHPLACE OF FATHER (State or Country),

Balto Co. Md.

12-MAIDEN NAME OF MOTHER

Lora Brancoe

13-BIRTHPLACE OF MOTHER (State or Country),

Balto Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Stephen L. Gloyd*(Address) *Sparks Md.*

15-

Filed

SEP 25 1915

191

ROBERT KRAUTER,

Morial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept *24*, 1915. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 17* 1915, to *Sept 24* 1915, that I saw her alive on *Sept 23* 1915, and that death occurred, on the date stated above, at *3:30 a.m.*

The CAUSE OF DEATH* was as follows:

Peripneumonia(Duration) yrs. mos. *25* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Walter L. Henry* M. D.*Sept 27*, 1915 (Address) *St. Josephs Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *7* ds. In the *21* yrs. mos. ds. StateWhere was disease contracted, if not at place of death? *Sparks Md.*Former or usual residence *Sparks Md.*

19-PLACE OF BURIAL OR REMOVAL

Sparks Md.

DATE OF BURIAL

Sept 25, 1915

20-UNDERTAKER

W.C. Brooks

ADDRESS

Sparks Md.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.....

PLACE OF DEATH

CITY OF BALTIMORE: (No.)

FULL NAME

(Residence in Baltimore: No.)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and RW out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

S-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

DATE OF BIRTH

AGE

IF LESS than

1 day, hrs.

OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(State or country)

NAME OF FATHER

BIRTHPLACE OF FATHER

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

March 1, 1915, to, Sept. 22, 1915,

that I saw her alive on Sept. 22, 1915,

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

Contributory (SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

SEP 25 1915

ROBERT KRAUTER,
Burial Permit Clerk
REGISTRARCathedral Sept 25, 1915
M. Fahy - Source Lafayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88401

CERTIFICATE OF DEATH.

28 C88401
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *915 Hanover* ST.; *24* WARD)2-FULL NAME *Rosa Wropruch*(Residence in Baltimore: No. *915 Hanover* St.; *43* yrs., *8* mos. *10* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH

Jan 12, 1872
(Month) (Day) (Year)

7-AGE

43 yrs., *8* mos., *10* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Housewife*

9-BIRTHPLACE, (State or Country)

Balto Md.

10-NAME OF FATHER

August Moeller

11-BIRTHPLACE OF FATHER (State or Country)

Germany

12-MAIDEN NAME OF MOTHER

Annie L

13-BIRTHPLACE OF MOTHER (State or Country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louis Wropruch*(Address) *915 Hanover St*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 22, 1915,
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 15* 1915, to *Sept 22* 1915, that I saw her alive on *Sept 21* 1915, and that death occurred, on the date stated above, at *6:37* m.

The CAUSE OF DEATH* was as follows:

Asthma - chronic

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *F. H. [Signature]* M. D.*915*...., 1915. (Address) *79 [Signature]*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSING, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. Is the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Western Cemetery

DATE OF BURIAL

Sept 25, 1915.

20-UNDERTAKER

H. F. M. G. [Signature]

ADDRESS

1424 Light St

15- SEP 25 1915

Filed

191

ROBERT KRAUTER, Registrar.

C88402 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 C88402
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 945 Sharp St. ST. 23 WARD)

2-FULL NAME

(No given name) Daughter of Wm & Rene Walker

(Residence in Baltimore: No. 945 Sharp St.)

St.; yrs., 0 mos. 0 ds. 14 hrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR-DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

September

23

1915

(Month)

(Day)

(Year)

7-AGE,

14 hours

If LESS than 1 day,

14 hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

None.

9-BIRTHPLACE,

(State or Country),

Maryland. Balto

10-NAME OF FATHER,

William Walker

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Rene Devry

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Walker

(Address) 703 S. Vermont St.

15-SEP 25 1915

ROBERT KRAUTER,

Filed..... 191.....

Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September

23

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....

Inquiry find that said deceased came to her death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY

(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) E. J. M. D.

(Coroner.)

Sept. 24, 1915. (Address) 377 Scott St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Auburn

Sept. 25, 1915

20-UNDERTAKER

ADDRESS

John H. Tradewell 142 W. Hill

C88403

Loretta Hackett
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 C88403
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2000 McKim* ST.; *20* WARD)

2-FULL NAME

(Residence in Baltimore: No. *2000 McKim* St.; — yrs., — mos. *4* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

Sept 20, 1915
(Month) (Day) (Year)

7-AGE,

4 yrs., — mos., — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Balto*

10-NAME OF FATHER,

*Thos Hackett*11-BIRTHPLACE OF FATHER
(State or Country),*Balto*

12-MAIDEN NAME OF MOTHER

*Delia Lamm*13-BIRTHPLACE OF MOTHER
(State or Country),*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Thos Hackett*(Address) *2000 McKim St*

15-

SEP 25 1915

Filed

ROBERT . KRAUTER,

Municipal Health Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 24, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 20, 1915*, to *Sept 24, 1915*, that I saw her alive on *Sept 23, 1915*, and that death occurred, on the date stated above, at *5 a.* m.

The CAUSE OF DEATH* was as follows:

Convulsion(Duration) ... yrs. ... mos. *8 hrs* ds.CONTRIBUTORY
(Secondary)*Premature birth*(Duration) ... yrs. ... mos. *4* ds.(Signed) *M. D.**Sept 24, 1915* (Address) *108 N. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

Sept 25, 1915

20-UNDERTAKER

Geo. L. Schmitt

ADDRESS

2101 Franklin

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

211 W. Montgomery St.

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Emma J. Moore

(Residence in Baltimore: No.

211 W. Montgomery St.

St.; 17 yrs., 8 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

Dec 22

(Month)

(Day)

(Year)

7-AGE,

17

yrs.

8

mos.

10

ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Housework
Domestic

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Joseph Moore

11-BIRTHPLACE OF FATHER (State or Country),

St Michaels Md.

12-MAIDEN NAME OF MOTHER

Mary C. Hanson

13-BIRTHPLACE OF MOTHER (State or Country),

Easton Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. White, Hyatt Md.

(Address)

35 E. Montgomery St.

15-

ROBERT . KRAUTER,

SEP 25 1915.

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 22

(Month)

(Day)

1915.

17- I HEREBY CERTIFY, That I attended deceased from July 23 1915, to Sept 22 1915, that I saw her alive on Sept 18 1915, and that death occurred, on the date stated above, at 9:35 Pm.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)

yrs.

3

mos.

ds.

CONTRIBUTORY (Secondary)

(Duration)

yrs.

1

mos.

ds.

(Signed)

J. White, Hyatt Md.

M. D.

Sept 23

1915

(Address)

35 E. Montgomery St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

1

yrs.

8

mos.

ds.

in the

17

yrs.

—

mos.

—

Where was disease contracted, if not at place of death?

Former or usual residence

Jasper St 608 for 8 yrs.

19-PLACE OF BURIAL OR REMOVAL,

St Peters Cemetery

DATE OF BURIAL,

Sept. 25 1915.

20-UNDERTAKER

Charles B. Jones

ADDRESS

1112 W. Saratoga St.

C88405

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88405

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *743 Raborg St.*)ST. *4*

WARD)

REGISTERED NO. C

FULL NAME

Henry Stevens

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *743 Raborg*)St. *30* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) *single*

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

54

yrs. mon. da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

General

9-BIRTHPLACE,

(State or Country).

New Jersey

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER

(State or Country).

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country).

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Amie J. J. J.*(Address) *743 Raborg St.*

15-

SEP 25 1915

Filed

191

ROBERT J. KRAUTER,

Municipal Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept. 23, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*
(Inquest, autopsy or inquiry.)and that said deceased came to *his* death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) yrs. *6* mos. da.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) *Wm. M. Savage* M. D.
(Coroner.)*Sept. 23, 1915* (Address) *1724 W. 1st St.*

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn Cemetery

DATE OF BURIAL,

Sept. 25, 1915

20-UNDERTAKER

Charles B. Jones

ADDRESS

1118 N. E. St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *1409 Gaubert*)

2-FULL NAME *Jacob Gaubert*

(Residence in Baltimore: No. *1409 Gaubert*)

ST. *24* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *10* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word)

6-DATE OF BIRTH *February 27, 1867*
(Month) (Day) (Year)

7-AGE *48* yrs. *6* mos. *23* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work *Shoemaker*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Hungary*

10-NAME OF FATHER *Jacob Gaubert*

11-BIRTHPLACE OF FATHER (State or country) *Hungary*

12-MAIDEN NAME OF MOTHER *Werner*

13-BIRTHPLACE OF MOTHER (State or country) *Hungary*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Jacob Gaubert*

(Address) *1409 Gaubert Street*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *September 23, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July*, 191*5*, to *September*, 191*5*, that I saw him alive on *19 September*, 191*5*, and that death occurred, on the date stated above, at *1-15* A. m. The CAUSE OF DEATH* was as follows:

Chronic emphysema of the lungs
Chronic degeneration

(Duration) yrs. *6* mos. ds. Contributory *metastasis in the lungs* (SECONDARY)

(Signed) *R. H. A. Meyer* (Duration) yrs. *1* mos. ds. (Address) *1618 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Western Cemetery

DATE OF BURIAL

Sept 25, 1915

UNDERTAKER

Christian Miller 2334 Jefferson

is very important. See instructions on back of certificate.

SEP 25 1915

ROBERT KRAUTER, Registrar

REGISTRAR

C88407

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88407

1 PLACE OF DEATH

CERTIFICATE OF DEATH

28 REGISTERED NO. C.

CITY OF BALTIMORE: (No. 1734 N. Calhoun St. 15

2-FULL NAME David A. Bryan

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 18.)

(Residence in Baltimore: No. 1734 N. Calhoun St.

St.; yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) single

6-DATE OF BIRTH unknown 1 (Month) (Day) (Year)

7-AGE 27 yrs. mos. ds. or min. 1 day, hrs. min. 2

8-OCCUPATION (a) Trade, profession or particular kind of work Clerk (b) General nature of industry, business, or establishment in which employed (or employer) office work

9-BIRTHPLACE (State or country) Md Balto

10-NAME OF FATHER James J. Bryan

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Annie C. Carroll

13-BIRTHPLACE OF MOTHER (State or country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James J. Bryan

(Address) 1734 N. Calhoun St.

15- SEP 25 1915 ROBERT KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept 23 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1915, to, Sept 23 1915, that I saw him alive on Sept 23 1915, and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

Contributory (SECONDARY) Myocarditis

(Signed) I. Fulem Sept 24 1915 [Address] 2040 Eutan Pl

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Catholic Cem

DATE OF BURIAL Sept 25 1915

20-UNDERTAKER Martin Fahy

ADDRESS 606 W. Lafayette Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88408

CERTIFICATE OF DEATH.

28 C88408

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 942 Leadenhall ST.; 23 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Willie White

(Residence in Baltimore: No. 942 Leadenhall

St.; 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

July 23, 1891
(Month) (Day) (Year)

7-AGE,

24 yrs., 7 mos., 1 ds.

10 LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Carpenter

9-BIRTHPLACE, (State or Country),

Washington, D.C.

PARENTS.

10-NAME OF FATHER,

Alexander White

11-BIRTHPLACE OF FATHER (State or Country),

Washington D.C.

12-MAIDEN NAME OF MOTHER

Charlotte Stewart

13-BIRTHPLACE OF MOTHER (State or Country),

Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary White

(Address)

942 Leadenhall

15-

SEP 25 1915

ROBERT H. RAUTER,

Filed

1915

Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September, 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov-10, 1914, to Sept 14, 1915, that I saw him alive on Aug-5-1915, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed)

D. J. Seaman, M. D.

Sept 24, 1915 (Address) 122 W. Lee St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn Ct

DATE OF BURIAL,

Sept 25, 1915

20-UNDERTAKER

L. H. Brown & Son

ADDRESS

18 N. Liberty St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88409

CERTIFICATE OF DEATH.

28

C88409

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Leadenhall ST. 23 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1011 Leadenhall St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH.

March 14, 1876
(Month) (Day) (Year)

7-AGE.

39 yrs. 0 mos. 0 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Shedder
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE.
(State or Country),Virginia

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ester Rich(Address) 1011 Leadenhall

15 SEP 25 1915

Filed..... 191. ROBERT KRAUTER,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 22, 1915
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from Sept 12 1915, to Sept 22 1915, that I saw him alive on Sept 21 1915, and that death occurred, on the date stated above, at 10 P. m. The CAUSE OF DEATH* was as follows:Pulmonary Tuberculosis
(Duration)..... yrs. 4 mos. ds.CONTRIBUTORY
(Secondary)(Signed) Walter H. White M. D.
Sept. 23, 1915. (Address) 1101 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

20-UNDERTAKER

DATE OF BURIAL.

ADDRESS

Not buried
Dr. Brown and Son
108 N. Montg

8

C88410

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 C88410

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1109 Russell St

ST. 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Matilda Brown

(Residence in Baltimore: No. 1109 Russell St

St.; yrs., — mos., 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, 43 yrs. 4 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country),

Queen Ann Co Md

10-NAME OF FATHER, Andrew Thomas

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Brown

(Address) 1109 Russell St

15-SEP 25 1915 ROBERT H. BRADLEY, Registrar.

Filed, 191, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1915. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonary

(Duration) yrs. 6 mos. 7 ds.

CONTRIBUTORY Exhaustion (Secondary)

(Duration) yrs. 7 mos. 7 ds.

(Signed) Edw. M. D. (Coroner.)

Sept. 24 1915 (Address) 517 Scott St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Form for usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Annesco Md DATE OF BURIAL, Sept 26, 1915

20-UNDERTAKER, L. B. Brown & Son ADDRESS, 108 N. Monty St

Cluster River Line Green Annesco Md

Important: See instructions on back of certificate.

C88411 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *115 N. Paca* ST.; *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Margaret Thompson*(Residence in Baltimore: No. *115 N. Paca St* St.; *24* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, *married*, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *Not known?*, *1884*
(Month) (Day) (Year)7-AGE, *31* yrs. *?* mos. *?* ds. If LESS than 1 day, hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Ireland*10-NAME OF FATHER, *Isidrael Bray*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER, *Mary Whalen*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm Bray*(Address) *108 S. Carey St*

15-SEP 25 1915

HARRY O. ANDREWS

Filed..... 191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept*, *24*, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *9-21-1915*, to *9-24-1915*, that I saw her alive on *9-23-1915*, and that death occurred, on the date stated above, at *3:30 a.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *2 yrs. 6 mon. ds.*CONTRIBUTORY *Chronic pneumonia, nephritis*
(Secondary)(Duration) *unknown* yrs. mon. ds.(Signed) *Chester Roland* M. D.*9-24-1915* (Address) *2532 Edmondson Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*New Cathedral Cemetery**Sept 27, 1915*

20-UNDERTAKER

ADDRESS

John F. Fields 12014 Lombard St

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 23rd WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. — yrs. 3 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

June 22

1915

7-AGE

— yrs. 3 mos. 2 ds.

If LESS than

1 day, hrs.

or — min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Baltimore Md

10-NAME OF FATHER

Henry Bromm

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore Md

12-MAIDEN NAME OF MOTHER

Alice M. Trust

13-BIRTHPLACE OF MOTHER
(State or country)

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Alice M Bromm (mother)

(Address)

1019 Patapsco St.

15

SEP 25 1915

HARRY O. ANDREWS,

Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September 24, 1915

(Month)

(Day)

(Year)

17.

I HEREBY CERTIFY, That I attended deceased from

September 22, 1915, to September 24, 1915,

that I saw him alive on September 24, 1915,

and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

Contributory
(SECONDARY)

Exhaustion

(Signed)

W. M. Remhardt M. D.
Sept 25, 1915 (Address) 1017 S Charles St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Western Cem.

DATE OF BURIAL

Sept 25, 1915

20-UNDERTAKER

E. Schloman & Son

ADDRESS

1039 Hanover St.

is very important. See instructions on back of certificate.

C88413

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88413

CERTIFICATE OF DEATH.

PLACE OF DEATH
Pronounced dead at Mercy Hospital
CITY OF BALTIMORE (No.) ST.: 11 WARD)

FULL NAME

William Jones.

(Residence in Baltimore: No. 21 E. Center St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male.

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Unknown, 1

(Month)

(Day)

(Year)

7-AGE,

55

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Galvan.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Bolton, England

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Records

(Address)

15-

SEP 25 1915.

HARRY O. ANDREWS,

Filed

191

Marital Permission

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September

20, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

arterio-sclerosis

(Duration) yrs. mos. ds.

(Signed) Wm. R. Chambers M. D.

(Coroner.)

Sept. 24, 1915. (Address) W. Frank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Grove Ridge Cemetery

DATE OF BURIAL,

Sept 25, 1915

20-UNDERTAKER

J. B. Cook

ADDRESS

1003 W. Belts

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104
C88414
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *828 S. Milton Ave.* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *828 S. Milton Ave.* St.; *Light* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white

5-SINGLE,

single
(Write the word.)

6-DATE OF BIRTH,

March 14, 1914
(Month) (Day) (Year)

7-AGE,

1 yrs. *6* mos. *9* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*none*9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*Joseph Bromer*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore*

12-MAIDEN NAME OF MOTHER

*Dora Gamuska*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Dora Bromer

(Address).

828 S. Milton Ave.

15- SEP 25 1915.

HARRY O. ANDREWS,

Filed..... 1915.

Serial Permit 0107

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 23, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Sept 1, 1915, to *Sept 23, 1915*,
that I saw her alive on *Sept 22, 1915*,
and that death occurred, on the date stated above, at *9 30 PM*

The CAUSE OF DEATH* was as follows:

Esenteric Enteritis(Duration)..... yrs. *1* mos. ds.CONTRIBUTORY
(Secondary)(Duration)..... yrs. mos. *4* ds.

(Signed).....

W. L. Burke D.*Sept 24, 1915*(Address)..... *3142 N. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary Bene

DATE OF BURIAL,

Sept 25, 1915

ADDRESS

20-UNDERTAKER

*Stephen J. Dziadosz**1012 S. ...*

is very important. See instructions on back of certificate.

C88415

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 C88415

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.: 45 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, hrs. or min.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

SEP 25 1915.

HARRY O. ANDREWS,
Serial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

C88416

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88416

CERTIFICATE OF DEATH.

28
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Mentor Ct. ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 716 Mentor Ct. St.; 48 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE

Colored5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Single

6-DATE OF BIRTH,

Unknown, 1867.
(Month) (Day) (Year)

7-AGE,

48 yrs., mos., ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-SEP 25 1915

Filed.....

191.....

HARRY O. ANDREWS,
Serial Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 24, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 21, 1915, to Sept. 24, 1915,that I saw him alive on Sept. 24, 1915,and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

Sept. 25, 1915, (Address) 611 N. Carroll St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel CemeterySept. 27, 1915

20-UNDERTAKER

ADDRESS

Robert A. Elliott546 Rogers Ave

C88417

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88417

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *610 Baker* ST.; *15* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *610 Baker St.* St.; *6* yrs., *6* mos., *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH.

Sept 6, 1890
(Month) (Day) (Year)

7-AGE.

25 yrs., *16* mos., *16* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*9-BIRTHPLACE.
(State or Country).*Northumberland Co Va*

PARENTS.

10-NAME OF FATHER.

*Isaac Armstrong*11-BIRTHPLACE OF FATHER
(State or Country).*Virginia*

12-MAIDEN NAME OF MOTHER

*Fannie Haynes*13-BIRTHPLACE OF MOTHER
(State or Country).*Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

William Washington
610 Baker St.

15-SEP 23 1915

HARRY O. ANDREWS,

Filed....., 191..

Serial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 22, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 22nd* 1915, to *Sept 22nd* 1915, that I saw her alive on *Sept 22nd* 1915, and that death occurred, on the date stated above, at *10:15 P.* m.

The CAUSE OF DEATH* was as follows:

Tuberculosis
Pulmonary
(Duration) *unknown* yrs. mos. ds.CONTRIBUTORY
(Secondary)(Signed) *W. H. Campbell* M. D.
Sept 25th 1915. (Address) *1369 N. Carey St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*St. Hubert**SEP 23, 1915*

20-UNDERTAKER

ADDRESS

*Samuel T. Murphy**578 N. Bond*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 N. Vincent ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Holland(Residence in Baltimore: No. 915 N. Vincent St.; 1 yrs., 9 mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored5-SINGLE, Infant
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Dec.21913

(Month)

(Day)

(Year)

7-AGE,

one

yrs.

9

mos.

24

da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),Balto. City

10-NAME OF FATHER,

John Holland11-BIRTHPLACE OF FATHER
(State or Country),Prince George's, Md.

12-MAIDEN NAME OF MOTHER

Bessie Clifford13-BIRTHPLACE OF MOTHER
(State or Country),Front Royal Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Holland(Address) 915 N. Vincent St.

15-

Filed

191

SEP 25 1915

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept.241915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 17 1915, to Sept. 24 1915, that I saw her alive on Sept. 23 1915, and that death occurred, on the date stated above, at 8-45 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) 8 mos. 8 da.CONTRIBUTORY
(Secondary)(Duration) 8 yrs. 8 mos. 8 da.(Signed) Chas. E. McParthy M. D.Sept. 24, 1915 (Address) 906 N. St. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 8 yrs. 8 mos. 8 da. In the State 8 yrs. 8 mos. 8 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Auburn LawnSept. 25, 1915

20-UNDERTAKER

ADDRESS

Mr. Edward W. Pye61 Winters Ave

C88419

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88419

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 ST. 14 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 511 McMechen St.; 25 yrs., 25 mos., 25 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)
Married

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

65If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Director9-BIRTHPLACE,
(State or Country),Virginia
for Jimmie

10-NAME OF FATHER,

Unknown11-BIRTHPLACE OF FATHER
(State or Country),Unknown

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bellina
(Address) 511 McMechen

15- SEP 25, 1915

HARRY O. ANDREWS,

Filed....., 191... Baltimore Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 24, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 21, 1915, to Sept 24, 1915, that I saw him alive on Sept 24, 1915, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) 7 yrs. 7 mos. 7 ds.CONTRIBUTORY Arterio Sclerosis with
(Secondary) Hypertension(Duration) 7 yrs. 7 mos. 7 ds.(Signed) Frank J. Murphy, M. D.Sept. 24, 1915. (Address) 1414 E. 14th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 3 yrs. 3 mos. 3 ds. In the 25 yrs. 25 mos. 25 ds.Where was disease contracted, if not at place of death? 511 McMechen St.Former or usual residence 511 McMechen St.

19-PLACE OF BURIAL OR REMOVAL

Moulton Balto Col.

DATE OF BURIAL,

Sept 26, 1915.

20-UNDERTAKER

F. B. Pye

ADDRESS

102 E. Mulberry St.

is very important. See instructions on back of certificate.

C88420

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91

C88420

PLACE OF DEATH

CITY OF BALTIMORE (No. 2717 Bernard St. 12 WARD)

FULL NAME

(Residence in Baltimore: No. 2717 Bernard St. yrs. 1 mos. 20 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6 DATE OF BIRTH Aug 4, 1915 (Month) (Day) (Year)

7 AGE 1 yrs. 20 mos. 20 ds. or less than 1 day, hrs. min.?

OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

SEP 25 1915

HARRY O. ANDREWS, Marial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 24th, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1915, to Sept. 24, 1915.

that I saw her alive on Sept. 24, 1915.

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion (Duration) few hours

Contributory (SECONDARY)

Broncho Pneumonia (Duration) 24 hrs. (Signed) F. C. Rehder, M.D. (Address) 112 N. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Marys Hospital, Sep 25, 1915

20 UNDERTAKER

ADDRESS

Chenoweth Son Chastnut Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88421

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; — yrs., 4 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE.

MARRIED.

WIDOWED.

OR DIVORCED.

(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).10-NAME OF
FATHER.11-BIRTHPLACE
OF FATHER
(State or Country).12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

SEP 25 1915

HARRY O. ANDREWS,

Serial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-I HEREBY CERTIFY, That I attended deceased from

to

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Exhaustion

Duration

CONTRIBUTORY

(Secondary)

(Duration)

(Signature)

(Address)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,

state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or

HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-

SIENTS, OR RECENT RESIDENTS).

At place of death

In the

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

1003 Wood

Baltimore, Md.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 N. Payson ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME Emma H. Dreitungross(Residence in Baltimore: No. 819 N. Payson St.; 16 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE White5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word.) Single

6-DATE OF BIRTH

June 6, 1890
(Month) (Day) (Year)

7-AGE,

12 yrs. 3 mos. 19 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Surgeon

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country), Germany10-NAME OF FATHER Alfred Breitungross11-BIRTHPLACE OF FATHER
(State or Country), Germany12-MAIDEN NAME OF MOTHER Hermine Dorneth13-BIRTHPLACE OF MOTHER
(State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant Alfred Breitungross)(Address) 819 N. Payson

15-SEP 25 1915

Filed.....

191.....

HARRY O. ANDREWS,
Bureau Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 25, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Septem. 18, 1915 to Septem. 25, 1915, that I saw her alive on Septem. 25, 1915, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Malignant Diphtheria(Duration).....yrs.....mos.....7 ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....John Hood.....M. D.Septem., 1915 (Address) 630 N. E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSFERS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Arwigburg

DATE OF BURIAL

Sept. 25, 1915

20-UNDERTAKER

H. J. Schumacher

ADDRESS

North Ave

8 A M

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88423

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88423

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

Hebrew Hospital ST.

REGISTERED No. C

92
6

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2 FULL NAME

Morris Vogel

(Residence in Baltimore: No.

205 N. Caroline

Sr.: *15* yrs. mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Sept

22

1900

(Month)

(Day)

(Year)

7 AGE

15

mos.

3

ds.

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

School

9 BIRTHPLACE

(State or country)

Baltimore

10 NAME OF FATHER

S. Vogel

11 BIRTHPLACE OF FATHER

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

B. Kendel

13 BIRTHPLACE OF MOTHER

(State or country)

Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Lewis

(Address)

1419 E. Baltimore

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

September 25, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

September 24, 1915, to September 25, 1915.

that I saw him live on *September 24, 1915.*

and that death occurred, on the date stated above, at *8:45 a.m.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. *3* ds.

Contributory (SECONDARY)

Acute Dilatation of heart

(Duration) yrs. mos. *1* ds.

(Signed), *H. David Silberman* M. D.

Sept 25, 1915 (Address) *Hebrew Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. *1* ds. In the *15* yrs. mos. ds.

Where was disease contracted, If not at place of death? *Residence*

Former or usual residence *205 N. Caroline St*

19 PLACE OF BURIAL OR REMOVAL

Hebrew Mt. Carmel

DATE OF BURIAL

9/26, 1915

20 UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Baltimore

SEP 26 1915

HARRY O. ANDERSON,
Corial Permit Clerk,
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 28.)

2-FULL NAME

(Residence in Baltimore: No. *1607 Harlem Ave* St.; *10* yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, *married*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

April 22, *1870*
(Month) (Day) (Year)

7-AGE,

45 yrs., *5* mos., *3* ds.If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*blank*
office work

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

- Dunbracco

11-BIRTHPLACE OF FATHER (State or Country),

unknown

12-MAIDEN NAME OF MOTHER

Mary Jackson

13-BIRTHPLACE OF MOTHER (State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry A. Eastman*(Address) *St. Mary's*

15-

SEP 26 1915 *HARRY A. EASTMAN*
Filed *to Baltimore City*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 25, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 1*, 1915, to *Sept 25*, 1915, that I saw him alive on *Sept 25*, 1915, and that death occurred, on the date stated above, at *8:20 a.m.*

The CAUSE OF DEATH* was as follows:

Ataxia paraplegia(Duration) *6* yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.(Signed) *Edward J. Conolly* M. D.*9/25*, 1915. (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., *25* mos., *45* ds. In the *45* yrs., mos., ds.Where was disease contracted, if not at place of death? *1607 Harlem Ave.*Former or usual residence *1607 Harlem Ave.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Woodlawn Cemetery *Sept. 27, 1915*

20-UNDERTAKER

ADDRESS

E. M. Mitchell & Co. 120 N. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *306 N. Fulton Ave*)

2-FULL NAME

(Residence in Baltimore: No. *306 N. Fulton Ave*)

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-MARRIED

Married

(Write the word.)

6-DATE OF BIRTH,

March 24, 1862

7-AGE,

*53**6* yrs. *—* mos. *—* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Sales Agent*9-BIRTHPLACE,
(State or Country),*W. Va.*

10-NAME OF FATHER,

*Henry Kratz*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Mary Fishman*13-BIRTHPLACE OF MOTHER
(State or Country),*Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Nannie B. Kratz

(Address)

306 N. Fulton Ave

15-

SEP 26 1915

File

HARRY O. ANDREWS

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Sep 24, 1915*17- I HEREBY CERTIFY, That I attended deceased from
Sep 14, 1915, to *Sep 24, 1915*,
that I saw him alive on *Sep 24, 1915*,
and that death occurred, on the date stated above, at *2:01 p.m.*
The CAUSE OF DEATH* was as follows:*Typhoid Fever*CONTRIBUTORY
(Secondary)(Signed) *Charles E. G.* *Sep 25, 1915* (Address) *114 N. Lombard St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

20-UNDERTAKER

G. M. Mitchell & Co.

DATE OF BURIAL,

Sep 27, 1915

ADDRESS

114 N. Fayette St.

C88426

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88426

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1500 Jackson* ST.; *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Henry A. Penick*(Residence in Baltimore: No. *1500 Jackson* St. *33* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Nov 24, 1846
(Month) (Day) (Year)

7-AGE,

74 yrs. *10* mos. *1* ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Sailor

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

W. C. Penick

11-BIRTHPLACE OF FATHER

(State or Country), *Germany*

12-MAIDEN NAME OF MOTHER

W. C. Penick

13-BIRTHPLACE OF MOTHER

(State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Penick*(Address) *1500 Jackson St.*

15-

SEP 26 1915

HARRY O. ANDREWS,

Baltimore Permit Office Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 25, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *July* 191*4*, to *Sept 25* 191*5*, that I saw him alive on *Sept 25* 191*5*, and that death occurred, on the date stated above, at *1:30 p.m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *R. P. Campbell* M. D.*Sept 25, 1915* (Address) *1644 Howard St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill

DATE OF BURIAL,

Sept 28, 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

C88427

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88427

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *909 NW hotcoat* ST.: *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Dennis Reid*(Residence in Baltimore: No. *909 NW hotcoat* St.: *3* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male*4-COLOR OR RACE. *colored*5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

Aug. 29, 1890
(Month) (Day) (Year)

7-AGE.

25 yrs. *26* mos. ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *store clerk*(b) General nature of industry, business, or establishment in which employed (or employer). *feeding & un-feeding boots*

9-BIRTHPLACE.

(State or Country), *Virginia*10-NAME OF FATHER, *William Reid*

11-BIRTHPLACE OF FATHER

(State or Country), *Virginia*12-MAIDEN NAME OF MOTHER *Fannie Fields*

13-BIRTHPLACE OF MOTHER

(State or Country), *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alberta Reid*(Address) *909 NW hotcoat St.*

15-

SEP 26 1915

HARRY O. ANDREWS,

Filed

191

Baltimore Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept. 24, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 14, 1915*, to *Sept. 24, 1915*, that I saw him alive on *Sept. 24, 1915*, and that death occurred, on the date stated above, at *6:30 P. M.* The CAUSE OF DEATH* was as follows:*Pulmonary Tuberculosis*
about 6
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Chas. L. Mc Carthy* M. D.
Sept. 25, 1915 (Address) *906 N. St. Charles St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*St. John's Church**Sept. 26, 1915*

20-UNDERTAKER

ADDRESS

*Sam. H. Chase & Son**400 N. Charles St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88428

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 E-20th ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Klueber(Residence in Baltimore: No. 1000 E-20th Street St. 9 W. 9 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) widow

6-DATE OF BIRTH,

May 4, 1840
(Month) (Day) (Year)

7-AGE,

75 yrs. 4 mos. 21 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

At home9-BIRTHPLACE,
(State or Country),Baltimore City

10-NAME OF FATHER,

John Selheffer11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Fredericka Esbeck13-BIRTHPLACE OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Charles E. Heinrichs

(Address)

1000 East 20th Street15- **SEP 26 1915.****MARY E. KLUEBER**

Filed....., 191...

Bartholomew Clark

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 25, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1915, to Sept. 25, 1915, that I saw her alive on Sept. 25, 1915, and that death occurred, on the date stated above, at 7:35 p.m. The CAUSE OF DEATH* was as follows:Cerebral Haemorrhage(Duration).....yrs.....mos. 14 ds.CONTRIBUTORY
(Secondary)Arterio Sclerosis(Signed) W. E. Sandrock M. D.Sept. 26, 1915. (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 14 ds. In the State.....yrs.....mos. 14 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore County

DATE OF BURIAL,

Sept. 28, 1915.

20-UNDERTAKER

William Cook

ADDRESS

502 E. North

C88429

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 167

C88429

1-PLACE OF DEATH *St Josephs Hospital*
 CITY OF BALTIMORE (No. *9* ST. *9* WARD)
 2-FULL NAME *James Gillease*
 (Residence in Baltimore: No. *St Josephs Hospital*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *Chesapeake* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*
 4-COLOR OR RACE, *White*
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
 (Write the word.)
 6-DATE OF BIRTH, *March 5th, 1911*
 (Month) (Day) (Year)

7-AGE, *4* yrs. *6* mos. *19* ds.
 If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER, *Michael B Gillease*
 11-BIRTHPLACE OF FATHER, *Md*
 12-MAIDEN NAME OF MOTHER, *Lauretta Murphy*
 13-BIRTHPLACE OF MOTHER, *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lauretta Gillease*
 (Address) *3500 100th St.*

15-SEP 26 1915

Filed 1915
 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 24, 1915*
 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry*
 (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry*
 (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

THE CAUSE OF DEATH was as follows:
Accidental burns 1st & 2nd degree of abdomen &c. caused by clothing of second degree ignited from playing with matches
 (Duration) ... yrs. ... mos. ... hours

CONTRIBUTORY (Secondary)

(Signed) *Mrs. M. Sarag* M. D.
 (Coroner.)
Sept. 24, 1915 (Address) *1724 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *6 hrs.* In the *4* yrs. *6* mos. *19* ds.

Where was disease contracted? If not at place of death?

at *3500 100th St. Baltimore*

Former or usual residence *3500 100th St. Baltimore*

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Mount Carmel

Sept. 26, 1915

20-UNDERTAKER

ADDRESS

Lilly Gillease

4008 W. 10th

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88430

C88430

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

915 S. Decker Ave

ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Catherine S. Rankin

(Residence in Baltimore: No.

915 S. Decker Ave

St.: — yrs., 10 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Nov

16

1914

(Month)

(Day)

(Year)

7-AGE,

yrs. 10 mos. 8 ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

None

None

9-BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Joseph Rankin

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Sadie Coyle

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs Sadie Rankin

(Address)..... 915 S. Decker Ave

15-

Filed.....

SEP 26 1915

HARRY O. ANDREWS,

Bureau Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 24th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 17th 1915, to Sept 24th 1915, that I saw h^e alive on Sept 23rd 1915, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration)..... yrs..... mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... David W. Jones M. D.

Sept 24, 1915 (Address)..... 3116 Edmond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Catholic Cem

DATE OF BURIAL,

Sept. 26th, 1915.

20-UNDERTAKER

Geo M. Fink

ADDRESS

811 N Wolfe

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Nursery & Childs Hospital* ST. 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Nursery & Childs Hospital* St. 18 yrs. 1 mos. 17 ds)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country)10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country)12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. G. Shetter*(Address) *Nursery & Childs Hospital*

15-

SEP 26 1915. HARRY O. ANDREWS,
Filed. 191... *Serial Pathology* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 25, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 9 1915, to *Sept 25* 1915,that I saw her alive on *Sept 24* 1915,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Alimentary Decomposition
C. Brown & L. Brown Malnutrition

(Duration) yrs. 1+ mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Edgar D. Frederick* M. D.*Sept 25*, 1915. (Address) *1516 Linden Ave.**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 16 ds. In the State yrs. 1 mos. 17 ds.

Where was disease contracted, if not at place of death? *unknown*Former or usual residence *unknown*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Landon Park Cemetery *Sept 27* 1915

20-UNDERTAKER

ADDRESS

George Smith *1516 Linden Ave.*

C88432

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88432

CERTIFICATE OF DEATH.

+ 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hospital* ST. *9* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *3307 Myrtle Place* St.: — yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Unknown, *1883*
(Month) (Day) (Year)

7-AGE,

62

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Bricklayer*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),*Maryland*

PARENTS.

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. Horner*(Address) *3307 Myrtle Place*

15-

SEP 26 1915

FILED 1915

HARRY C. ANDERSON
BALTIMORE PUBLIC CLERK

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 25, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 24* 1915, to *Sept 25* 1915, that I saw him alive on *Sept 25* 1915, and that death occurred, on the date stated above, at *6:15 P.* m.

The CAUSE OF DEATH* was as follows:

Ch. Interstitial Nephritis(Duration) *3* yrs. *3* mos. *3* ds.CONTRIBUTORY *Uremic Poisoning*
(Secondary)(Duration) *3* yrs. *3* mos. *3* ds.(Signed) *Ernest H. Riegs* M. D.*Sept 25*, 1915. (Address) *St Josephs Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *1* mos. *1* ds. In the *62* yrs. *3* mos. *3* ds.Where was disease contracted, if not at place of death? *3307 Myrtle Pl.*Former or usual residence *3307 Myrtle Pl.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Carmel Cemetery, *Sept 27*, 1915.

20-UNDERTAKER

ADDRESS

Christian Miller *2035 Jefferson St*

PHYSICIAN should
Exact statement of OCCUPATION
is very important. See instructions on back of certificate.

C88433

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88433

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *147 East St*)

ST. *5*

WARD)

2-FULL NAME

Lidia C. Gross

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

(Residence in Baltimore: No. *147 East St*)

ST. *Lifeline*

YRS. *6*

MON. *3*

DS. *1*

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED

Married
(Write the word)

6-DATE OF BIRTH

Nov

21, 1864

7-AGE

51 yrs. *6* mos. *3* ds.

IF LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic

9-BIRTHPLACE (State or country)

Beth. City, Md

10-NAME OF FATHER

Thomas Timmons

PARENTS

11-BIRTHPLACE OF FATHER (State or country)

Md

12-MAIDEN NAME OF MOTHER

Caroline Chaney

13-BIRTHPLACE OF MOTHER (State or country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daniel Gross
147 East St

(Address)

SEP 26 1915.

Filed, 1915

HARRY C. ANDREWS

Barred for not being

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept.

24

1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *July 30, 1915*, to *Sept 24, 1915*, that I saw her alive on *Sept. 24, 1915*, and that death occurred, on the date stated above, at *5 A. m.* The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. *6* mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

Robert J. Green

M. D.

Sept 25, 1915

(Address) *120 1/2 Wisconsin St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Abney Cemetery

DATE OF BURIAL

Sept 27, 1915

20-UNDERTAKER

Chas H Bailey

ADDRESS

Jefferson St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 806 S Lakewood ST.; 1 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 806 S Lakewood St. Life time yrs. 0 mos. 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) Single

6-DATE OF BIRTH.

Sept 11, 1914
(Month) (Day) (Year)

7-AGE.

1 yrs. 14 mos. 0 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),Balt City

10-NAME OF FATHER.

John Gost11-BIRTHPLACE OF FATHER
(State or Country).Balt City

12-MAIDEN NAME OF MOTHER

May E Harrison13-BIRTHPLACE OF MOTHER
(State or Country),Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Gost

(Address)

806 S Lakewood

15-

SEP 26 1915

HARRY O. ANGLER

Filed

191

Serial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 25, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Aug 5 1915, to Sept 24 1915,
that I saw him alive on Sept 24 1915,
and that death occurred, on the date stated above, at 12:50 m.

The CAUSE OF DEATH* was as follows:

Enteritis(Duration) 1 yrs. 10 mos. 20 ds.CONTRIBUTORY
(Secondary)Exhaustion(Duration) 7 yrs. 3 mos. 5 ds.

(Signed)

W L Long M. D.9/25, 1915. (Address) 2701 Eastern

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Green Hill Cem

DATE OF BURIAL.

Sept 27, 1915.

20-UNDERTAKER

Stephen J. Michowski

ADDRESS

1012 S. Kinner St.

C88435

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 C88435

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 6 S. Ellwood Ave.

ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Brown,

(Residence in Baltimore: No. 6 S. Ellwood Ave.

St.: 48 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Widow (If more than one word)

6-DATE OF BIRTH

January 9, 1860
(Month) (Day) (Year)

7-AGE

65 yrs. 9 mos. 15 ds. or less than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
At Home

9-BIRTHPLACE
(State or country)

Germany

10-NAME OF FATHER

Henry Wick

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Annie Schoepflein

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anna Rotimon

(Address)

6 S. Ellwood Ave

15 SEP 26 1915

HARRY O. ANDREWS,

Serial 300011 Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September 24, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 30, 1915, to Sept., 24, 1915,

that I saw her alive on Sept., 24, 1915, and that death occurred, on the date stated above, at 12:30 A.M. The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Clinical Diagnosis)

About (Duration) yrs. 8 mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

Allen C. Buchanan

M. D.

Sept., 24, 1915. (Address) 3139 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt. Carmel Cemetery

DATE OF BURIAL

Sept., 27, 1915.

20-UNDERTAKER

Zirkel & Zirkel

ADDRESS

1739 E. Eager

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1124 N. Calvert* ST.; *11* WARD)

REGISTERED NO. C

2-FULL NAME

Nannah R. Lawrence

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1124 N. Calvert* St.; *65* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Sept Feby 1830
Sept Feby 26, 1915
(Month) (Day) (Year)

7-AGE,

85 yrs. *6* mos. *30* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *At Home*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Cecil Co., Md

10-NAME OF FATHER,

Samuel Thomas

11-BIRTHPLACE OF FATHER (State or Country),

Cecil Co Md

12-MAIDEN NAME OF MOTHER

Millicent Jones

13-BIRTHPLACE OF MOTHER (State or Country),

Cecil Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Baldwin Goodwin*
(Address) *1124 N. Calvert St.*

15-

SEP 26 1915

HARRY O. ANDREWS,

1915

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 25, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *1910* to *Sept 25* 191*5*, that I saw her alive on *Sept 25* 191*5*, and that death occurred, on the date stated above, at *8:45* a.m.

The CAUSE OF DEATH* was as follows:

Old age

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

Pulmonary oedema (probably
(Secondary) *incipient labor pneumonia)*
(Duration).....yrs.....mos.....ds.(Signed) *Geo. T. Kemp* M. D.*Sept. 25, 1915.* (Address) *Charles & Center St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.....mos.....ds. In the Stateyrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Goodwin & Son

DATE OF BURIAL,

Sept. 27, 1915

20-UNDERTAKER

H. W. Jenkins & Son Co

ADDRESS

McCallister

C88437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

C88437

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1419 Belmont*)

ST. *14* WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

May Henson

(Residence in Baltimore: No. *1419 Belmont*)

St. *14* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

female

4-COLOR OR RACE,

col.

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

married

6-DATE OF BIRTH,

Nov.

(Month)

(Day)

1888

(Year)

7-AGE,

28

YRS.

9

mos.

ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

housewife no regular paid occupation

9-BIRTHPLACE,

(State or Country).

Va.

10-NAME OF FATHER,

Sixon

11-BIRTHPLACE OF FATHER

(State or Country).

Va

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER

(State or Country).

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lewis Henson (husband)*

(Address) *1419 Belmont St.*

15-

SEP 27 1915

ROBERT J. KRAUTER

Chief Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept.

25

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from about first of *May* 1915, to *Sept. 25* 1915, that I saw her alive on *Sept. 24* 1915, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

about 10 or 12

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *L. F. Shumwell* M. D.

Sept. 25, 1915 (Address) *2226 Madison Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mark Anson

DATE OF BURIAL,

Sept. 27, 1915

20-UNDERTAKER

John H. Owens

ADDRESS

1222 Hume St.

88438

HEALTH DEPARTMENT—CITY OF BALTIMORE

88438

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Maternity* 19 WARD)

2-FULL NAME *Howard C. Wilcox, Jr.*

(Residence in Baltimore: No. *Franklin Square Maternity* yrs. mos. 7 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *male* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)

6-DATE OF BIRTH, *Sept. 19, 1915*
(Month) (Day) (Year)

7-AGE, *7* yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Franklin Sq. Maternity, Baltimore

10-NAME OF FATHER *Howard C. Wilcox*

11-BIRTHPLACE OF FATHER (State or Country). *Ind.*

12-MAIDEN NAME OF MOTHER *Etta Meseke*

13-BIRTHPLACE OF MOTHER (State or Country). *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Etta Wilcox, mother*

(Address) *2215 Madison ave.*

15- *SEP 27 1915* **ROBERT J. KRAUTER** *Undertaker*

SEP 27 1915 **ROBERT J. KRAUTER** *Undertaker*
Burial Permit Clerk's 20-UNDEBTAKER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 26, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *birth* to *Sept. 26, 1915*, that I saw him alive on *Sept. 26, 1915*, and that death occurred, on the date stated above, at *3:30 p. m.*

The CAUSE OF DEATH* was as follows:
meningitis, probably from forceps injury at time of birth.
(Duration) *Symptoms only one day*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) *L. F. Shennwell* M. D.
Sept. 26, 1915 (Address) *2226 Madison ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State yrs. mos. 7 ds.

Where was disease contracted, if not at place of death? *Franklin Square Hosp.*

Former or usual residence *Franklin Square Hosp.*

19-PLACE OF BURIAL OR REMOVAL, *Franklin Square Hosp.*

DATE OF BURIAL, *Sept. 27, 1915*

ADDRESS *St. Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1711 Guilford Ave* ST.; *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Roy Thomas Meeks*(Residence in Baltimore: No. *1711 Guilford Ave* St.; *—* yrs., *—* mos. *9* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE. *White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Sept. 17, 1915*

(Month)

(Day)

(Year)

7-AGE, *—* yrs., *—* mos., *9* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *at home*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country), *Baltimore Md.*

PARENTS.

10-NAME OF FATHER, *Thomas Henry Meeks*11-BIRTHPLACE OF FATHER
(State or Country), *Chase, Md.*12-MAIDEN NAME OF MOTHER *Mina Garback*13-BIRTHPLACE OF MOTHER
(State or Country), *Chase, Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thomas H. Meeks*(Address) *1711 Guilford Ave*

15-

ROBERT J. KRAUTER

SEP. 27 1915

Registrar:

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *September 26, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept. 17, 1915*, to *Sept. 26, 1915*, that I saw him alive on *Sept. 26, 1915*, and that death occurred, on the date stated above, at *11:20 a.m.*

The CAUSE OF DEATH* was as follows:

Congenital Syphilis(Duration) *—* yrs., *—* mos., *9* ds.CONTRIBUTORY
(Secondary)(Duration) *—* yrs., *—* mos., *—* ds.(Signed) *Edwin B. Fenty, M. D.**Sept. 26, 1915. (Address) 1223 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Chase & Remick, Chase, Md.*DATE OF BURIAL, *Sept. 27, 1915*

20-UNDERTAKER

ADDRESS *H. O. Hughes 17 Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Josephs Hosp.* ST.; *9* WARD)

REGISTERED NO. C.....

2-FULL NAME

(Residence in Baltimore: No. *St. Josephs Hosp.* St.; *7 1/2* yrs., *7* mos., *—* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)6-DATE OF BIRTH, *March 28th 1873* (Month) (Day) (Year)7-AGE, *42* yrs., *6* mos., *3* ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Manager* (b) General nature of industry, business, or establishment in which employed (or employer), *Grocery Dept.*9-BIRTHPLACE, (State or Country), *Ireland*PARENTS. 10-NAME OF FATHER, *John Keane* 11-BIRTHPLACE OF FATHER (State or Country), *Ireland* 12-MAIDEN NAME OF MOTHER, *Ann Carroll* 13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Keane*(Address) *Hamilton Md.*

15-ROBERT KRAUTER, Registrar.

SEP 27 1915, File No. *101* Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 25, 1915* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 25* 1915, to *Sept 25* 1915, that I saw him alive on *Sept 25* 1915, and that death occurred, on the date stated above, at *8:10 p.m.*

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) *Exhaustion*

(Duration).....yrs.....mos.....ds.

(Signed) *R. M. Cullough* M. D.*Sept 25* 1915. (Address) *St. Josephs Hosp.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *7 1/2* yrs. In the *35* mos. State *7* yrs. mos. ds.Where was disease contracted, if not at place of death? *?*Former or usual residence *Hamilton Md.*19-PLACE OF BURIAL OR REMOVAL, *Hartford Conn.* DATE OF BURIAL, *Sept 28, 1915*20-UNDERTAKER, *Chas. S. Evans & Son* ADDRESS *180 W. Mt. Royal Ave.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *145 W Montgomery* ST. *22* WARD)

2-FULL NAME

Hanna Barnes

(Residence in Baltimore: No. *145 W Montgomery*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

abt 16

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, *Married*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Dec (Month) *1* (Day), *1860* (Year)

7-AGE,

54 yrs. (Month) *4* mos. (Day) *16* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Calvert County

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edna Barnes*

(Address) *145 W Montgomery*

15-

SEP 27 1915

Filed..... 191

ROBERT KRAUTER

Morial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept (Month) *26* (Day), *1915* (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. (Inquest, au-

inquest and that said deceased came to *death* (Inquest, au-
topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy
Le. d. disease
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) *Edna Barnes* M. D.
(Coroner) *Left 26*, 1915. (Address) *317 N. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death.... yrs. mos. ds. State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Calvert Co. Md

Sept 28, 1915

UNDERTAKER

ADDRESS

La. Brown and Son
Sares Wolff Calvert Co. Md

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 28 Talbot St-

2-FULL NAME

(Residence in Baltimore: No. 28 Talbot St-

St.: 9

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

August 30

1915

(Month)

(Day)

(Year)

7-AGE,

24

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Balt City

10-NAME OF FATHER,

Thomas Groode

11-BIRTHPLACE OF FATHER

(State or Country)

Cumberland Va

12-MAIDEN NAME OF MOTHER

Martha Curry

13-BIRTHPLACE OF MOTHER

(State or Country)

Cumberland Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mother Martha's Groode

(Address)

28 Talbot St - Balt

15-

SEP 27 1915

Filed

ROBERT

KRAUTER

Marital Permit Clerk

Registrar.

16-DATE OF DEATH,

Sept 23

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. C. Rogers, D.

1915 (Address) 306 Rodgers St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

Int-Aurion Ave

DATE OF BURIAL,

Sept 27, 1915

20-UNDERTAKER

Robert A Elliott

ADDRESS

306 Rodgers St

Important. See instructions on back of certificate.

C88443

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88443

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *920 S. Paca* ST. *21* WARD)2-FULL NAME *Amelia Gustaitis*(Residence in Baltimore: No. *920 S. Paca* St.; yrs. *2* mos. *18* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*Single*

6-DATE OF BIRTH

July 7 - 1915
(Month) (Day) (Year)

7-AGE

2 mos. 18 ds. or min.?If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE
(State or country)*Balt City*

10-NAME OF FATHER

*Andrus Gustaitis*11-BIRTHPLACE OF FATHER
(State or country)*Russia*

12-MAIDEN NAME OF MOTHER

*Mary Kamickas*13-BIRTHPLACE OF MOTHER
(State or country)*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Andrus Gustaitis*(Address) *920 S. Paca St.*

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

Sept. 25, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Sept 16, 1915, to, Sept 25, 1915,
that I saw her alive on *Sept. 22, 1915,*
and that death occurred, on the date stated above, at *6 P.M.*

The CAUSE OF DEATH* was as follows:

Cholera Infantum(Duration) yrs. mos. *10 ds.*Contributory
(SECONDARY)

(Signed)

John S. Kladowsky M.D.
Sept 26, 1915 [Address] *629 Columbia Ave*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *920 S. Paca St.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Holy Redeemer**Sept 27, 1915*

20-UNDERTAKER

ADDRESS

John Grebliauskas 500 S. Paca St.

15-

SEP 27 1915

ROBERT KRAUTER

Burial Permit Clerk
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88444

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2042 Lafayette Ave 12 ST.; WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

3-FULL NAME

(Residence in Baltimore: No. 2042 Lafayette Ave St.; yrs. 30 min. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

Single

6-DATE OF BIRTH,

Sept 25 1915
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,
...hrs. or 30 min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Baltimore Md

10-NAME OF FATHER,

Peter J. Perrin

11-BIRTHPLACE OF FATHER
(State or Country),

Balto Md

12-MAIDEN NAME OF MOTHER

Grace First

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter J. Perrin

(Address) 304 E. Lenoir St.

15-

SEP 27 1915

Filed..... 1915

ROBERT KRAUTER,

Chief Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 25 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 25 1915, to Sept 25 1915,

that I saw him alive on Sept 25 1915,

and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Premature birth

male 4 months

(Duration)..... yrs..... mos..... da.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... da.

(Signed) Reginald J. Down M. D.

Sept 25, 1915. (Address) 1114 E. Lenoir St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Bury

DATE OF BURIAL,

Sept 27 1915

20-UNDERTAKER

Martin P. Hayes & Sons

ADDRESS

1114 E. Lenoir St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 436 W. Biddle street, ST. 11 WARD)

*FULL NAME Jane S. Thomas,

(Residence in Baltimore: No. 436 W. Biddle street,

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 40¹¹² mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed,

6-DATE OF BIRTH, July 4th, 1842. (Month) (Day) (Year)

7-AGE, 73 yrs., 2 mos., 20 da. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland,

10-NAME OF FATHER, Benjamin Jennings,

11-BIRTHPLACE OF FATHER (State or Country), Maryland,

12-MAIDEN NAME OF MOTHER, Rosetta Brown,

13-BIRTHPLACE OF MOTHER (State or Country), Maryland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophie S. Redden, daughter,

(Address) 436 W. Biddle street.

15-ROBERT . KRAUTER, Registrar.

SEP 27 1915, 191. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 24, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) And that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably sclerosis of Coronary arteries.

(Duration) yrs. mos. da.

CONTRIBUTORY...Arterio-sclerosis, (Secondary)

(Duration) yrs. mos. da.

(Signed) J. H. Hemmley, M. D. (Coroner)

Sept. 25 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. da. In the State, yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn City

DATE OF BURIAL, SEP 27 1915

20-UNDERTAKER, Samuel S. Hemmley

ADDRESS, 578 Biddle St

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *1516* *Trachon Ave.* ST.; *13* WARD)2-FULL NAME *Isch Lieberman Baumbly*(Residence in Baltimore: No. *1516* *Trachon Ave.* St.; yrs., mos. *12* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE. *White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH. *Sept 14, 1915*

(Month)

(Day)

(Year)

7-AGE, yrs. mos. *12* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *clerk*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Balto Md*10-NAME OF FATHER, *Lieberman Baumbly*11-BIRTHPLACE OF FATHER (State or Country), *Balto Co Md*12-MAIDEN NAME OF MOTHER *Hoda Hale*13-BIRTHPLACE OF MOTHER (State or Country), *Balto Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *Lieberman Baumbly*(Address)..... *1516 Trachon Ave*

15-

SEP 27 1915

ROBERT M. KRAUTER,

Bureau Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 26, 1915*

(Month)

(Day)

(Year)

15- I HEREBY CERTIFY, That I attended deceased from *Sept 14* 1915, to *Sept 26* 1915, that I saw her alive on *Sept 20* 1915, and that death occurred, on the date stated above, at *5 A* m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis(Duration)..... yrs. mos. *12* ds.

CONTRIBUTORY (Secondary).....

(Duration)..... yrs. mos. ds.

(Signed)..... *D. S. Leonard* M. D.*Sept 26* 1915 (Address)..... *2003 Emma Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSFERS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Hampstead Md.*DATE OF BURIAL, *Sept 27, 1915*20-UNDERTAKER, *B. E. Fink*ADDRESS, *2024 Wilkens Ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88447

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 C88447

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1509 E. Chase

2 FULL NAME

Margaret Spickemuth

(Residence in Baltimore: No. 1509 E. Chase

St. 12 yrs. 9 mos. 19 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

6 DATE OF BIRTH 12 6, 1852 (Month) (Day) (Year)

7 AGE 62 yrs. 9 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

10 NAME OF FATHER John Knier

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Cook

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 SEP 27 1915

Filed

191

ROBERT J. KRAUTER,

Bureau Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9 25, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1912, to Sep 25, 1915, that I saw her alive on Sep 24, 1915, and that death occurred, on the date stated above, at 11 a.m. The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart with Delata hie

Contributory (SECONDARY) Rheumatism (Duration) 2 yrs. 7 mos. 5 ds.

(Signed) Edmund W. DeWitt M. D. Sep 26, 1915 (Address) 207 Bay View

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Sep 28, 1915

20 UNDERTAKER Henry Horck Sun ADDRESS 1301 E. Bay View

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1019 N. Wolf St*ST. *7* WARD)

REGISTERED NO. C

2-FULL NAME

Ferdinand Kress

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1019 N. Wolf St*St.; *11* yrs., *11* mos., *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

June 11, 1865
(Month) (Day) (Year)

7-AGE,

50 yrs., 3 mos., 14 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Pressman

(b) General nature of industry, business, or establishment in which employed (or employer).

Printing shop

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

John Kress

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Frances Kucher

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Elizabeth Kress

(Address)

1019 N. Wolf St

15-SEP 27 1915

ROBERT J. KRAUTER,

Filed....., 191.....

Official Public Health

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 25, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*August 18, 1915, to Sept 24, 1915*that I saw him alive on *Sept 24, 1915*and that death occurred, on the date stated above, at *8-9 m.*

The CAUSE OF DEATH* was as follows:

Chronic Liver
and Congestion of Liver
(Duration) *2 yrs., 11 mos., 14 ds.*

CONTRIBUTORY

(Secondary)

Dyspepsia
(Duration) *1 yrs., 11 mos., 14 ds.*

(Signed)

Chas. J. Morris M. D.*Sept 25, 1915* (Address) *1025 N. Wolf St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oak Lawn Cemetery *Sept 28, 1915*

20-UNDERTAKER

ADDRESS

Harry Houches *1301 E. Coates*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

August

(Month)

2nd, 1852

(Day)

(Year)

7-AGE:

63

yrs.

1

mos.

24

ds.

or

min.?

IF LESS than

1 day,

hrs.

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Baltimore, Md.

10-NAME OF FATHER

Jacob Green

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Anne Garland Howison

13-BIRTHPLACE OF MOTHER
(State or country)

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Raymond H. Williams

(Address)

519 Rose Hill Terrace

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

Sept

26, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1913, to Sept 26, 1915,

that I saw him alive on Sept 26, 1915, and that death occurred, on the date stated above, at 6:50 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Exam. of findings)

(Duration)

2

yrs.

mos.

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

Sept 27, 1915

[Address]

Wentworth St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, HOMICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Greenmount Cemetery

DATE OF BURIAL

Sept 28, 1915

20-UNDERTAKER

Henry L. Moore & Son

ADDRESS

805 N Calvert St

15-

SEP 27 1915

ROBERT KRAUTER,

Burial Permit Clerk

REGISTRAR

THIS IS VERY IMPORTANT. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Mersey Hospital*)FULL NAME *Philip March*(Residence in Baltimore: No. *226 S. Gilman*)

REGISTERED No. C

ST. *19* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *6* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

6-DATE OF BIRTH,

*August**23*, 18*86*

7-AGE,

*69**1* yrs. *W* mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Gen. Contractor retired

9-BIRTHPLACE,

(State or Country),

City

10-NAME OF FATHER,

Philip March

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Ellen Taylor

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annie Weaver (daughter)*(Address) *226 S. Gilman*

15-

SEP 27 1915

Filed

ROBERT

KRAUTER

Baptist Board of Missions

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*September**25*, 1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquiry* (Inquest, au-

topsy or inquiry.) find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy - cerebral(Duration) *few hours*

CONTRIBUTORY (Secondary)

(Duration) *few hours*(Signed) *Thos. M. Hanrahan* M. D. (Coroner.)*Sept. 27*, 191*5* (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *2 hours* In the of death *2 hours* mos. ds. State *2 hours* yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence *226 S. Gilman*

19-PLACE OF BURIAL OR REMOVAL

Mount Olivet Cemetery

DATE OF BURIAL

Sept. 27, 191*5*

20-UNDERTAKER

H. J. H. H. H.

ADDRESS

1421 N. E. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88451

93 C88451

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

Church Home & Infirmary 48 ST.; 48 WARD)

Ernest Doetsch
2323 East Eager Place

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Sept 29, 1900
(Month) (Day) (Year)

7-AGE,

15 yrs. 11 mos. 28 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

School boy

9-BIRTHPLACE,
(State or Country).

Baltimore, Md.

10-NAME OF FATHER,

John Doetsch

11-BIRTHPLACE OF FATHER
(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Sophia Bodenschlag

13-BIRTHPLACE OF MOTHER
(State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Doetsch

(Address)

2323 E. Eager St.

15-

SEP 27 1915

Filed

ROBERT

KRAUTH

Baltimore County

20-UNDERTAKER

Registrar.

H. H. C. Huller

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 26, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Sept 26 1915 Sept 26 1915

that I saw him alive on Sept 26 1915

and that death occurred, on the date stated above, at 10⁴⁵ P.M.

The CAUSE OF DEATH* was as follows:

Empyema
Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. Ramonell Starr, M. D.

Sept 26 1915 (Address) Church Home & Infirmary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

at home

Former or usual residence

2323 E. Eager Place

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore County

Sept. 30, 1915

ADDRESS

321 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88452

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88452

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

Hebrew Hosp.

ST.

WARD)

2-FULL NAME

Sadie Ridgway

(Residence in Baltimore: No.

1437 E. Monument

ST.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

Mar 6, 1888

7-AGE

27 yrs. 6 mos. 20 ds. or less than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Houseworks

9-BIRTHPLACE
(State or country)

Md. Balto

10-NAME OF FATHER

John J. Mauley

11-BIRTHPLACE OF FATHER
(State or country)

Balto Md

12-MAIDEN NAME OF MOTHER

Mary Bowen

13-BIRTHPLACE OF MOTHER
(State or country)

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mae Mauley

(Address)

409 1/2 Caculiny

15.

ROBERT J. KRAUTER

Morial Permit Clerk

SEP 27 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

Sept. 26, 1915

17. I HEREBY CERTIFY, That I attended deceased from 8/20, 1915, to 9/26, 1915.

that I saw h. Ea. alive on 9/26/1915.

and that death occurred, on the date stated above, at 3:29 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Typhoid Fever

(Duration) 2 yrs. - mos. - ds.

Contributory Uremic Coma & Cerebral Hemorrhage

(SECONDARY)

(Duration) 3 yrs. - mos. - ds.

(Signed) M. B. Levine M. D.

9/26, 1915. (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death - yrs. - mos. 27 ds. In the 27 yrs. - mos. - ds.

Where was disease contracted, Home 1437 E. Monument

If not at place of death? Former or usual residence 1437 E. Monument St.

19-PLACE OF BURIAL OR REMOVAL

Balto Cemetery

DATE OF BURIAL

Sept 29, 1915

UNDERTAKER

John Turner 184 24 Bowry

PHYSICIANS should
state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION
is very important. See instructions on back of certificate.

C88453

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 C88453
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 539 N. Larkwood Ave. 7
2-FULL NAME Martin William Hall
(Residence in Baltimore: No. 539 N. Larkwood Ave. 7 yrs. 11 mos. 26 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male
4-COLOR OR RACE White
5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single
6-DATE OF BIRTH Sep 29, 1867
7-AGE 47 yrs. 11 mos. 26 ds.
8-OCCUPATION Clerk Chesapeake Steamship

9-BIRTHPLACE (State or country) Balt. Md.
10-NAME OF FATHER William Absolom Hall
11-BIRTHPLACE OF FATHER (State or country) Balt. Md.
12-MAIDEN NAME OF MOTHER Mary Eliz. McElree
13-BIRTHPLACE OF MOTHER (State or country) Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John R. Hall
(Address) 1729 E. Larrale

15. SEP 27 1915

ROBERT KRAUTER
Municipal Health Officer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sep 26, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 26, 1915, to Sep 26, 1915, that I saw him alive on Sep 26, 1915, and that death occurred, on the date stated above, at 4:20 a.m.
The CAUSE OF DEATH* was as follows:

Acute Indigestion
Organic Heart Disease
Contributory (SECONDARY)
(Signed) Louis Vogel M. D.
Sep 26, 1915 (Address) 2691 E. Mount St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Address 14424 Broadway

John A. Vain
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12011. Washington ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 12011. Washington St. 5 yrs., 1 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

June 3rd, 1859
(Month) (Day) (Year)

7-AGE.

56 yrs., 3 mos., 22 ds.If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Bookster9-BIRTHPLACE,
(State or Country).Baltimore Md.

10-NAME OF FATHER,

John A. Vain11-BIRTHPLACE OF FATHER
(State or Country).Baltimore Md.

12-MAIDEN NAME OF MOTHER

Not Known13-BIRTHPLACE OF MOTHER
(State or Country).Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charlie Vain(Address) 12011. Washington St.

15-

SEP 27 1915

ROBERT KRAUTER,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept. 25, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1915, to Sept 25 1915, that I saw him alive on Sept 25 1915, and that death occurred, on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
and Nephritis(Duration) ... yrs. ... mos. 14 ds.CONTRIBUTORY
(Secondary)Exhaustion (Duration) ... yrs. ... mos. 2 ds.(Signed) Dr. H. C. Eisner M. D.Sept. 26, 1915. (Address) 7201-3 E. Ave. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Cal Lawn Cem.

DATE OF BURIAL.

Sept 28 1915.

20-UNDERTAKER

H. Sander

ADDRESS

1716 Reade St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 Super Block ST.; 19 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1308 Super Block St.; Life yrs., 0 mos., 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH.

March 4TH 1838
(Month) (Day) (Year)

7-AGE.

77 yrs., 6 mos., 0 ds.If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Unknown9-BIRTHPLACE,
(State or Country).Baltimore

10-NAME OF FATHER.

Geo W Squires11-BIRTHPLACE OF FATHER
(State or Country)A.A. County Md

12-MAIDEN NAME OF MOTHER

Margaret Landragen13-BIRTHPLACE OF MOTHER
(State or Country).Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Brooks(Address) 1708 Calhoun St15- SEP 27 1915 ROBERT KRAUTERFiled 191 1708 Calhoun St

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 26, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1915, to Sept 26 1915, that I saw her alive on Sept 25th 1915, and that death occurred, on the date stated above, at 6 45 pm.

THE CAUSE OF DEATH* was as follows:

Old age complicated with Bronchitis Asthma
(Duration) 0 yrs., 0 mos., 0 ds.CONTRIBUTORY
(Secondary)(Signed) Henry B. Kall M. D.
Sept 26, 191... (Address) 1203 1st St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mount Olivet 9-28-1915

20-UNDERTAKER

ADDRESS

Robert Brooks Calhoun St

20

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88457

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Emerson Hotel* ST.; *4* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Emerson Hotel* St.; *65* yrs., *9* mos., *24* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the words)

Single

6-DATE OF BIRTH,

December 3, 1847
(Month) (Day) (Year)

7-AGE,

65 yrs., *9* mos., *24* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*none**none*

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Joseph Robt

11-BIRTHPLACE OF FATHER (State or Country),

Philadelphia

12-MAIDEN NAME OF MOTHER

Elizabeth Jones

13-BIRTHPLACE OF MOTHER (State or Country),

Denton N. J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Ernest Gil

(Address)

Emerson Hotel

15-

SEP 27 1915
Filed....., 1915

ROBERT

KRAUTER

Burial Permit No. 1101

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

9 *27*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 12* 1915, to *Sept 27* 1915, that I saw her alive on *Sept 27* 1915, and that death occurred, on the date stated above, at *2-9* a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis(Duration) *5* yrs., *5* mos., *5* ds.

CONTRIBUTORY (Secondary)

Carcinoma Stomach(Signed) *James C. Clark* M. D.*Sept 27*, 1915.. (Address) *1201 Madison Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*London Park Cemetery**Sept 29*, 1915

20-UNDERTAKER

ADDRESS

*Stewart & Brown Company**105 W. N. St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

On sidewalk at the cor. of
CITY OF BALTIMORE (No. Fremont ave. and Mosher st. ST. 18 WARD)

REGISTERED NO. C

FULL NAME

Arthur L. Baker,

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 912 West Franklin st.

St.; yrs., 2 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOW, OR DIVORCED, Married, (Write the word.)

6-DATE OF BIRTH, November 24th, 1880. (Month) (Day) (Year)

7-AGE, 34 yrs., 10 mos., 2 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Automobile (b) General nature of industry, business, or establishment in which employed (or employer), mechanic.

9-BIRTHPLACE, (State or Country), Washington, D. C.

10-NAME OF FATHER, William Baker,

11-BIRTHPLACE OF FATHER, Unknown, (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown,

13-BIRTHPLACE OF MOTHER, Unknown, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Flora Baker, wife,

(Address) 912 W. Franklin street.

15-ROBERT KRAUTER, Registrar.

SEP 27 1915, 191. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 26th, 1915. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry and that said deceased came to his death topay or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation.

(Duration) yrs. mos. ds.

CONTRIBUTORY Chronic alcoholism, (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

Sept. 27, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, In the State, yrs. 2 mos. 22 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Washington, D. C.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

10-UNDERTAKER, ADDRESS

Stewart Mornice 10820 North Ave.

important. See instructions on back of certificate.

Michelo Menulo
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.:

yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH.

October 31, 1914.
(Month) (Day) (Year)

7-AGE.

11 yrs. mos. ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.
(State or Country).

Md. Balto

PARENTS.

10-NAME OF FATHER.

Luigi Menulo

11-BIRTHPLACE OF FATHER

(State or Country).

Italy

12-MAIDEN NAME OF MOTHER

Jose Theresa

13-BIRTHPLACE OF MOTHER

(State or Country).

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP 27 1915

ROBERT KRAUTER

Filed..... 1915.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

September 26, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 20 1915 to Sept 26 1915, that I saw him alive on Sept 26 1915, and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows:

Cerebro-meningitis - Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Sept. 27 1915 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

1007 E. Lombard St.

19-PLACE OF BURIAL OR REMOVAL.

St. Vincent's

DATE OF BURIAL.

Sept. 27, 1915

20-UNDERTAKER

Lilly Zivier

ADDRESS

4038 W. 11th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *18* WARD)2-FULL NAME *Frederick Fliescher*(Residence in Baltimore: No. *830 W Pratt St*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *50* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

unknown; 1836

(Month)

(Day)

(Year)

7-AGE,

79

yrs. — mos. — ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

*Frederick Fliescher*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Not known*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frederick Fliescher*(Address) *830 W Pratt St*

15-

SEP 27 1915

Filed..... 191.....

ROBERT E. KRAUTH

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 27, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Sept 26 1915, to Sept 27 1915,*that I saw him alive on *Sept 27* 1915,and that death occurred, on the date stated above, at *4:30* m.

The CAUSE OF DEATH* was as follows:

Diffuse Peritonitis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY

Ruptured Intestine following Strangulated hernia

(Duration)..... yrs. mos. ds.

(Signed)

R. L. Johnson

M. D.

Sept 27, 1915. (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

830 W Pratt St

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*London Park Cu**Sept 27, 1915*

UNDERTAKER

ADDRESS

Mrs A. P. Johnson

C88461 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

C88461

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's German Hospital*)

REGISTERED NO. C.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number; and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *534 W. Lexington St.*)St.; *20* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

unknown, 1 (Month) (Day) (Year)

7-AGE,

20 yrs., mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Carroll Paquarilla

11-BIRTHPLACE OF FATHER (State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Winkler

13-BIRTHPLACE OF MOTHER (State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joe Colla(Address) *534 W. Lexington St.*

15-

SEP. 27 1915

ROBERT KRAUTER,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 26, 191*5* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 16* 191*5*, to *Sept 26* 191*5*, that I saw him alive on *Sept 26* 191*5*, and that death occurred, on the date stated above, at *5:30 p. m.*

The CAUSE OF DEATH* was as follows:

Syphilitic Fever -
Neural Degeneration(Duration) *10* yrs., mos. ds.
CONTRIBUTORY (Secondary) *Neural Degeneration*(Duration) *1* yrs., mos. ds.(Signed) *Alfred V. Pennington* M. D.*Sept 26*, 191*5*. (Address) *St. Joseph's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *10* yrs., mos. ds. In the State *10* yrs., mos. ds.Where was disease contracted, if not at place of death? *not known*Former or usual residence *534 W. Lexington St.*

19-PLACE OF BURIAL OR REMOVAL,

St. Vincent Ave

DATE OF BURIAL,

20-UNDERTAKER

Mrs. A. Rolderson

ADDRESS

730

1. This is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88462

CERTIFICATE OF DEATH

64 C88462
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 Baker St. 14 WARD)

2-FULL NAME Julia Butler

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 12.)

(Residence in Baltimore: No. 632 Baker St.; yrs. mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE Colored 5-SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH Don't know 1852 (Month) (Day) (Year)

7-AGE 63 If LESS than 1 day, hrs. yrs. mos. ds. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work Domestic (b) General nature of industry, business, or establishment in which employed (or employer) Private Family

9-BIRTHPLACE (State or country) Charlotte Co. Va.

10-NAME OF FATHER Richard Carrington

11-BIRTHPLACE OF FATHER (State or country) Charlotte Co. Va.

12-MAIDEN NAME OF MOTHER Millie Boxdale

13-BIRTHPLACE OF MOTHER (State or country) Charlotte Co. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. William Fry MD

(Address) 1928 Penn Ave

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept 26 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 1915 to Sept 26 1915, that I saw her alive on Sept 26 1915, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 3 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) E. William Fry MD M. D. Sept 26 1915 [Address] 1928 Pa. Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death yrs. mos. In the ds. State yrs. mos. 3 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laurel Cemetery

Sept 28th 1915

20-UNDERTAKER

ADDRESS

Helix B. Pye

1028 Marlboro

18-SEP 27 1915
Filed 191

ROBERT KRAUTER,
Medical Permit Clerk
REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Thames Str,

ST.:..... WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Schmidt.

(Residence in Baltimore: No.

1616 Thames Str.

St.: 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX,
Male4-COLOR OR RACE,
White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) Married

6-DATE OF BIRTH,

Not Known,

(Month)

(Day)

1870 (Year)

7-AGE,

45

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Schoemaker,
Factory

9-BIRTHPLACE,

(State or Country),

German Poland,

10-NAME OF
FATHER,

Albert Schmidt,

11-BIRTHPLACE
OF FATHER

(State or Country),

Not Known

12-MAIDEN NAME
OF MOTHER

Not Known

13-BIRTHPLACE
OF MOTHER

(State or Country),

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).... Mary Schmidt,

(Address).... 1616 Thames Str.

15-

Filed

SEP 27 1915

191

ROBERT KRAUTER,

Municipal Health Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 9 1915 to Sept 26 1915,

that I saw him alive on Sept 26, 1915,

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Circulation of Liver
(Duration) Not KnownCONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Benj. D. Harrison M. D.

Sept 27, 1915 (Address) 1216 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,
Holy Rosary,DATE OF BURIAL,
Sept. 28 1915.

20-UNDERTAKER

William Fialkowski

ADDRESS

1618 Eastern,
Ave,

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *17*)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *533 W. Hoffman St.*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Cel*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH.

June 22, 1915
(Month) (Day) (Year)

7-AGE,

3 yrs. *3* mos. *3* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Me

10-NAME OF FATHER,

John Briss

11-BIRTHPLACE OF FATHER (State or Country),

Me

12-MAIDEN NAME OF MOTHER

Bessie James

13-BIRTHPLACE OF MOTHER (State or Country),

Me

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

SEP 27 1915

ROBERT

KRAUTH,

Municipal Health Clerk,

Registrar.

18-PLACE OF BURIAL OR REMOVAL,

COLLEGE OF P. & S.

DATE OF BURIAL,

SEP 27 1915

20-UNDERTAKER

Commissioner Health.

ADDRESS

Per, Wm E. WOODALL.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 23, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 5, 1915* to *Sept. 23, 1915*, that I saw him alive on *Sept. 23, 1915*, and that death occurred, on the date stated above, at *1:15* p.m. The CAUSE OF DEATH* was as follows:
Premature Birth

CONTRIBUTORY (Secondary)

(Duration).....yrs. *1* mos. *1* ds.
(Signed) *Frank M. M...* M. D.
533 W. Hoffman St. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. *3* mos. *3* ds. In the State.....yrs. *3* mos. *3* ds.Where was disease contracted, if not at place of death? *Birth*Former or usual residence *533 W. Hoffman St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88455

CERTIFICATE OF DEATH.

28

C88465

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1649 E. Bayar ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1649 E. Bayar

St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH,

May 3, 1874

(Month)

(Day)

(Year)

7-AGE,

41 yrs. 4 mos. 23 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,

(State or Country), Ireland

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER

(State or Country), Ireland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Edeyn Stran

(Address), 437 E. 21 St.

15-

SEP 27 1915.

ROBERT

KRAUTER,

Official Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 26, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended, deceased from

March 1915, to Sept 26, 1915

that I saw him alive on Sept 26, 1915

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Coronary Arteriosclerosis

(Duration) 3 yrs. mos. ds.

(Signed) E. W. Connelley M. D.

Sept 26, 1915. (Address) 74 N. Fulton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cem

DATE OF BURIAL,

Sept 28, 1915

20-UNDERTAKER

Wm Cook

ADDRESS

107 E. No. 24

Wm Connelley 74 N. Fulton St.

C88466

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88466

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *1232 Riverside Ave* ST.; *24* WARD)

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

Edith G. King(Residence in Baltimore: No. *1232 Riverside Ave* St. *25* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED, *married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July *5*, *1890*
(Month) (Day) (Year)

7-AGE,

25 yrs., *2* mos., *21* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....*Home*9-BIRTHPLACE,
(State or Country),*Balto*10-NAME OF
FATHER,*John A. Marley*11-BIRTHPLACE
OF FATHER
(State or Country),*Balto*12-MAIDEN NAME
OF MOTHER*Elizabeth Loresel*13-BIRTHPLACE
OF MOTHER
(State or Country),*Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Benj. G. King*(Address) *1232 Riverside Ave*

15-

*ROBERT J. KRAUTER*Filed *SEP 27 1915*

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 26, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Sept 11, *1915*, to *Sept 26*, *1915*,that I saw her alive on *Sept 25*, *1915*,and that death occurred, on the date stated above, at *1045* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Pneumonia*

(Duration) yrs. mos. ds.

(Signed) *Wm. Cook* M. D.*Sept 26*, *1915* (Address) *1232 Riverside Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

SEP 29 1915

UNDERTAKER

Wm. Cook

ADDRESS

502 E North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 784 E 28 ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl N. Cole(Residence in Baltimore: No. 784 E 28 St.; 9 yrs., 7 mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.) Single

6-DATE OF BIRTH,

Dec.201914

(Month)

(Day)

(Year)

7-AGE,

9 yrs., 7 mos., 7 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE,

(State or Country), Balt. Co. Md.10-NAME OF FATHER, William Cole

11-BIRTHPLACE OF FATHER

(State or Country), Balt. Md.12-MAIDEN NAME OF MOTHER Lucy Cornelius

13-BIRTHPLACE OF MOTHER

(State or Country), Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. N. Cole(Address) 784 E 28

15-

Filed 1914

191

ROBERT

K. H. HARTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept. 271915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 231915

to

Sept 271915

that I saw him alive on

Sept 27and that death occurred, on the date stated above, at 2:29 m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis(Duration) 7 yrs., 7 mos., 7 ds.

CONTRIBUTORY (Secondary)

Sick(Duration) 7 yrs., 7 mos., 7 ds.(Signed) Geo. H. Murgatroyd, M.D.Sept 271915(Address) 2507 E. Frederick Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Indew Park Cemetery

DATE OF BURIAL.

Sept 29

20-UNDERTAKER

Arkway Home Inc

ADDRESS

1301 E. Bay St.

C88468

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88468

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2612 Shirley Ave* ST. *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Emma D. Watson*(Residence in Baltimore: No. *2612 Shirley Ave* St.: yrs. mos. *4* *hrs.* *15* *ds.*)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *Sept. 26, 1915*

(Month)

(Day)

(Year)

7-AGE,

yrs. mos. da.

If LESS than 1 day.

4 hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Md.*

PARENTS.

10-NAME OF FATHER, *Wm. L. Watson*11-BIRTHPLACE OF FATHER (State or Country), *Washington D.C.*12-MAIDEN NAME OF MOTHER *Emma J. Whalen*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. L. Watson*(Address) *2612 Shirley Ave*

15-

Filed

SEP 27 1915

W. BERT KRAUTER,
Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 26, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 26, 1915*, to *Sept 26, 1915*, that I saw him alive on *Sept 26, 1915*, and that death occurred, on the date stated above, at *8:15 P.M.*

The CAUSE OF DEATH* was as follows:

Prematurely born about 6 1/2 months fetus

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) *James S. Whitcomb* M. D.*9-27-15* (Address) *4612 Park Heights Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Louder Park Cemetery*DATE OF BURIAL, *Sept. 27, 1915*

20-UNDERTAKER

ADDRESS

Mrs. J. E. Evans & Sons 428 E. Charles

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88469 HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

172 C88469
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2561 W. Fairmount Ave. St. 20 WARD)

2-FULL NAME Isaac C. Baker

(Residence in Baltimore: No. 2561 W. Fairmount Ave. Sr. 10 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

6-DATE OF BIRTH May 25, 1832 (Month) (Day) (Year)

7-AGE 83 yrs. 4 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Chester Co Pa

10-NAME OF FATHER

Eli Baker

11-BIRTHPLACE OF FATHER (State or country)

Chester Co Pa

12-MAIDEN NAME OF MOTHER

Sarah Clayton

13-BIRTHPLACE OF MOTHER (State or country)

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. Clayton Baker

(Address) 2016 W. Lexington St

15-

ROBERT . KRAUTER,

Filed , 1915 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept. 27, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY. That I attended deceased from

Sept 23, 1915, to Sept 27, 1915.

that I saw him alive on Sept 26, 1915.

and that death occurred, on the date stated above, at 5:45 pm.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Accidental fall down steps

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Traumatic Palsy (Duration) yrs. mos. ds.

(Signed) Thos. A. Schaefer M. D.

Sept 27, 1915 (Address) 2505 W. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Stewartstown - Pa. -

DATE OF BURIAL

Sept. 29, 1915

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 West Baltimore St

SEP 27 1915

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88470

CERTIFICATE OF DEATH

92 C88470
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 Carlisle Place 8

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 11.)

2-FULL NAME

Mary P. Przak

(Residence in Baltimore: No. 1701 Carlisle Place

St.; 20 yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7-AGE

About 65 years

If LESS than

1 day, hrs.,

1/2 mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

Retail liquor business

9-BIRTHPLACE

(State or country)

Austria (Bohemia)

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER

(State or country)

Bohemia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or country)

Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis Waders (Son)

(Address)

128 N. Castle St

15-

ROBERT J. KRAUTER,

Deputy Registrar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September

25

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1915, to Sept 25, 1915, that I saw her alive on Sept 25, 1915, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Total pneumonia

(Duration)

7

ds.

Contributory (SECONDARY)

Chronic Myocarditis

(Duration)

1

ds.

(Signed)

Edgar P. Sandrock

M. D.

Sept 25, 1915

(Address)

1601 N. Broadway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

Yrs.

Mos.

ds.

In the

State

Yrs.

Mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Sept 28, 1915

20-UNDERTAKER

ADDRESS

Harry Lutz

1007 N. Bond

SEP 27 1915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *706 S. Register* ST. *2* WARD)2-FULL NAME *Antonia Razulak*(Residence in Baltimore: No. *706 S. Register* St.; *35* yrs. *7* mos. *20* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*6-DATE OF BIRTH, *March 14, 1863*

(Month)

(Day)

(Year)

7-AGE, *52 yrs. 7 mos. 20 ds.*

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *House work at home*(b) General nature of industry, business, or establishment in which employed (or employer) *home*9-BIRTHPLACE, (State or Country), *Germany Poland*10-NAME OF FATHER, *Not known*11-BIRTHPLACE OF FATHER (State or Country), *German Poland*12-MAIDEN NAME OF MOTHER *Not known*13-BIRTHPLACE OF MOTHER (State or Country), *Germany Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Kullak*(Address) *706 S. Register*

15-SEP 27 1915

Filed:

101

HARRY O. ANDREWS,

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 27, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 27, 1915*, to *Sept 27, 1915*, that I saw her alive on *Sept 26, 1915*, and that death occurred, on the date stated above, at *2 30* m.

The CAUSE OF DEATH* was as follows:

Prothral Hemorrhage

CONTRIBUTORY (Secondary)

Cardiac Failure (Duration) *4* yrs. *4* mos. *4* ds. *Sept 27, 1915* (Address) *2008 Atlantic*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *4* yrs. *4* mos. *4* ds. In the State *4* yrs. *4* mos. *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Rosary*DATE OF BURIAL, *Sept 29, 1915*20-UNDERTAKER *M. F. Sudowski*ADDRESS *705 S. Ann St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88472

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88472

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Water foot of Bush St ST. 21 WARD)

2-FULL NAME William Gains

(Residence in Baltimore: No. None)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Unknown

St. yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

55

yrs. mos. ds.

If LESS than 1 day.

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

General

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

John Gains

11-BIRTHPLACE OF FATHER

(State or Country).

Baltimore

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Albert Wunder.....

(Address).....1160 Sargeant St.....

15-SEP 27 1915

Filed..... 191.....

Serial Form 11-10-15

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

26

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-

inquiry

.....and that said deceased came to his death
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

Found in water foot of Bush St

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....

(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....Edmund M. D......
(Coroner.)

...Sept. 27 1915... (Address) 517 Scott St.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cem

Sept 28, 1915

20-UNDERTAKER

Wm J. Tickner & Sons

ADDRESS

Imperial

CEAP

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2356 McCulloh St.; 13 WARD)2-FULL NAME Ruth M. Barwick (Barwick)(Residence in Baltimore: No. 2356 McCulloh St.; 33 yrs., 2 mos., 14 da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female4-COLOR OR RACE, White5-SINGLE, married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, July 10, 1882

(Month)

(Day)

(Year)

7-AGE, 33 yrs., 2 mos., 14 da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md. (Baltimore City)10-NAME OF FATHER, Henry Hicks11-BIRTHPLACE OF FATHER (State or Country), Md12-MAIDEN NAME OF MOTHER, Florence Lora13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Barwick(Address) 2356 McCulloh St.

15-

SEP 27 1915

HARRY O. ANDREWS,

Filed....., 191.....

Serial-For-File-Only
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep 26, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from Sep 20 1915, to Sep 26 1915, that I saw him alive on Sep 26 1915, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Sub-acute Nephritis(Duration) 1 yrs., 1 mos., 1 da.CONTRIBUTORY (Secondary) Acute Glomerulonephritis(Duration) 1 yrs., 1 mos., 1 da.(Signed) Arthur G. Brown M. D.9-26, 1915 (Address) 1631 Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London ParkDATE OF BURIAL, Sep 28, 191520-UNDERTAKER, Mrs. A. RohdeADDRESS, 730 Park

Important. See instructions on back of certificate.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

C88475

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88475

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *Franklin Square Hopt*)
FULL NAME *Arthur H. Maxwell*
(Residence in Baltimore: No. *1524 N. Chapel St.*)

172
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Male</i>	4-COLOR OR RACE. <i>white</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>married</i> (Write the word.)
6-DATE OF BIRTH. <i>Oct.</i> , <i>1872</i> (Month) (Day) (Year)		
7-AGE. <i>43</i> yrs. <i>11</i> mos. ds. If LESS than 1 day, ... hrs. or ... min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Printer</i> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE. (State or Country), <i>Md</i>		
PARENTS. 10-NAME OF FATHER, <i>Robert Maxwell</i> 11-BIRTHPLACE OF FATHER (State or Country), <i>Md.</i> 12-MAIDEN NAME OF MOTHER, <i>Liveton Harvery</i> 13-BIRTHPLACE OF MOTHER (State or Country), <i>Md.</i>		

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Amos B. Town*
(Address) *1847 W. Pratt*

15-SEP 27 1915
Filed SEP 27 1915
HARRY O. ANDERSON
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept*, *24*, *1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accident
Pilot of scaffold when rope broke
(Duration) yrs. mos. ds.
CONTRIBUTORY *Fractured skull* (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Samuel H. Hensley* M. D. (Coroner.)
Sept. 27, 1915 (Address) *2302 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death? *Orlando, Fla. Commerce St.*
Former or usual residence *1524 N. Chapel St.*

19-PLACE OF BURIAL OR REMOVAL, *West 9th St. Cemetery*
DATE OF BURIAL, *Sept 22, 1915*
20-UNDERTAKER, *Waverly*
ADDRESS, *Robert S. Sumner on Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88476

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2624-26 Hudson* ST.;WARD) *1*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2624-26 Hudson St*St. *24* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-STATUS
MARRIED,
OR DIVORCED,
(Write the word.) *Married*

6-DATE OF BIRTH,

*Feb**6**1872*

(Month)

(Day)

(Year)

7-AGE,

*42**7**20*

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...*Saloon Keeper*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

Mikolaj Gzyboski

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Tekla Wisniowski

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sharyna Gzyboski*(Address) *2624-26 Hudson St*

15-SEP 27 1915

HARRY O. ANDREWS

Filed..... 191..... Burial Permit. Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Sept -**25 -**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Aug 10**1915*, to *Sept 25**1915*that I saw h... alive on *Sept 25* 191and that death occurred, on the date stated above, at *11-20 P.M.*

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis(Duration)..... yrs. *3* mos. ds.CONTRIBUTORY
(Secondary)(Duration)..... yrs. *1* mos. ds.

(Signed)..... M. D.

Sept 27, 1915. (Address) 125 S. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St Stanislaus Cem**28 Sept., 1915.*

20-UNDERTAKER

ADDRESS

*Stephen Frankowski**1015 S. Kenwood Ave*

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. *1817 Lancaster*ST.; *V* WARD)

REGISTERED NO. C

2-FULL NAME *Bronislaw Tefilowski*(Residence in Baltimore: No. *1817 Lancaster*St.; *Life* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, *Single*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Mar 31, 19*15*
(Month) (Day) (Year)

7-AGE,

5 yrs. *28* mos. *28* ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country), *Baltimore Md.*10-NAME OF FATHER, *Frank Tefilowski*

11-BIRTHPLACE OF FATHER

(State or Country), *Russia Poland*12-MAIDEN NAME OF MOTHER *Antonina Czelepa*

13-BIRTHPLACE OF MOTHER

(State or Country), *Russia Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Tefilowski*(Address) *1817 Lancaster St.*

15-

SEP 27 1915

HARRY O. ANDREWS,

B. 101 Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 27, 191*5*
(Month) (Day) (Year)

17-I HEREBY CERTIFY That I attended deceased from

Sept 25 191*5*, to *Sept 27* 191*5*,that I saw him alive on *Sept 29* 191*5*,and that death occurred, on the date stated above, at *7* a.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

.....

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *W. H. H. H. H. H.*

..... (Duration) yrs. mos. ds.

(Signed) *G. A. Lader* M. D.*7/27*, 191*5* (Address) *1817 Lancaster St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Sept 28, 191*5*

20-UNDERTAKER

M. F. Sadovskiy

ADDRESS

708 S. Ann

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88478

CERTIFICATE OF DEATH.

100 C88478
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *503 E. Montgomery*)

ST. *22* WARD)

(If death occurred in a hospital or institution, give its NAME (instead of street and number and fill out No. 18.)

2-FULL NAME

Alfred Earl Hoppe

(Residence in Baltimore: No. *503 E. Montgomery*)

St. *9* yrs. *8* mos. *29* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Single

6-DATE OF BIRTH.

Dec. 27, 1905
(Month) (Day) (Year)

7-AGE.

9 yrs. *8* mos. *29* ds.

If LESS than 1 day.
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

School

9-BIRTHPLACE, (State or Country).

Maryland Balt

10-NAME OF FATHER.

Gustave Alfred Hoppe

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER.

Margaret Eslinger

13-BIRTHPLACE OF MOTHER (State or Country).

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anna Eslinger et*

(Address) *503 E. Montgomery St.*

SEP 28 1915

ROBERT KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept. 26, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 24* 1915, *Sept 26* 1915, that I saw him alive on *Sept 25* 1915, and that death occurred, on the date stated above, at *4: A* m.

The CAUSE OF DEATH* was as follows:

Septicaemia

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. *2* ds.

(Duration) ... yrs. ... mos. *3* ds.

(Signed) *G. F. Denton* M. D.

Sep. 27, 1915 (Address) *301 Oak Street*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds. State ...

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Lorraine Cem.

DATE OF BURIAL.

Sept. 28, 1915

20-UNDERTAKER

Edw. J. Hamming

ADDRESS

1460 Battery Ave.

Important. See instructions on back of certificate.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Mary Hospital* ST. *24* WARD)

2-FULL NAME *Katherine Williamson*

(Residence in Baltimore: No. *1551 Ludlow St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

July (Month)

4 (Day)

1892 (Year)

7-AGE,

23 yrs.

2 mos.

23 ds.

It LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Housewife

9-BIRTHPLACE,

(State or Country),

City

10-NAME OF FATHER,

John F. Seiner

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Minnie Beck

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Clarence Williamson

(Address)...

1551 Ludlow St.

15-

SEP 28 1915

ROBERT KRAUTER

Morial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September (Month)

26, 191*5* (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

Autopsy & Inquiry (Inquest, Autopsy or Inquiry)

thereon and from the evidence obtained by said

Autopsy (Inquest, etc.)

4 Inquiry and that said deceased came to her death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis following self inflicted abortion 4 weeks ago at a two months pregnancy

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *W. R. Hamilton* M. D.

(Coroner.)

Sept. 27, 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos. *13* ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

1551 Ludlow St. W. J.

Former or usual residence *1551 Ludlow St. W.*

19-PLACE OF BURIAL OR REMOVAL,

Mt Olivet Cem.

DATE OF BURIAL,

Sept 29, 191*5*

20-UNDERTAKER

Edw. S. Fanning

ADDRESS

1460 Battery Av.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital* REGISTERED NO. C
 CITY OF BALTIMORE: (No. *152* ST. *4* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)
 2-FULL NAME *Baby Heil*
 (Residence in Baltimore: No. *220 Barney* St.; *0* yrs. *0* mos. *0* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH, *9-17-1915*
 (Month) (Day) (Year)

7-AGE, *0* yrs. *0* mos. *9* ds. If LESS than 1 day, *hrs.* or *min.*

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *None*
 (b) General nature of industry, business, or establishment in which employed (or employer). *None*

9-BIRTHPLACE, (State or Country), *Md. Balto*

10-NAME OF FATHER, *Henry Heil*

11-BIRTHPLACE OF FATHER (State or Country), *Md.*

12-MAIDEN NAME OF MOTHER *Elizabeth Dorsette*

13-BIRTHPLACE OF MOTHER (State or Country), *Ill.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Heil*

(Address) *220 E. Barney*

15-SEP 28 1915 ROBERT. KRAUTER,
 Filed 191. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *9-26-1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *9-17-1915*, to *9-26-1915*, that I saw her alive on *9-26-1915*, and that death occurred, on the date stated above, at *6:30* p.m.

The CAUSE OF DEATH* was as follows:

Consequential Ataxia

(Duration) *0* yrs. *0* mos. *0* ds.
 CONTRIBUTORY (Secondary) *Pneumonia*

(Duration) *0* yrs. *0* mos. *0* ds.
 (Signed) *P. L. Rush* M. D.
9-26-1915 (Address) *University Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs. *0* mos. *0* ds. In the State *0* yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death? *220 E. Barney*

Former or usual residence *220 E. Barney*

19-PLACE OF BURIAL OR REMOVAL, *London Pk. Cem.* DATE OF BURIAL, *Sept. 28, 1915*

20-UNDERTAKER *J. James McNally* ADDRESS *87 E. Bay*

Important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *3048* *Donnell*)ST. *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Wm. J. Griffiths*(Residence in Baltimore: No. *3048* *Donnell*)St. *60* yrs. *3* mos. *22* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*
(Write the word)6-DATE OF BIRTH *June 5th, 1855*
(Month) (Day) (Year)7-AGE *60* yrs. *3* mos. *22* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work *Boat Keeper*
(b) General nature of industry, business, or establishment in which employed (or employer) *Am. Agric. Chem. Co.*9-BIRTHPLACE
(State or country)*Baltimore*

PARENTS

10-NAME OF FATHER

*Wm. Griffiths*11-BIRTHPLACE OF FATHER
(State or country)*Wales*

12-MAIDEN NAME OF MOTHER

*Phoebe Jones*13-BIRTHPLACE OF MOTHER
(State or country)*Wales*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Alfred K. Jones
Koslyn Hall C.

15-SEP 28 1915

ROBERT J. KRAUTER,
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept. 27, 1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY. That I attended deceased from *Sept 15th, 1915*, to *Sept 27th, 1915*, that I saw him alive on *Sept 26th, 1915*, and that death occurred, on the date stated above, at *9* a. m. The CAUSE OF DEATH* was as follows:*Bronchitis acute*(Duration) yrs. mos. *10* ds.Contributory
(SECONDARY)*Myocardial Insufficiency*(Duration) *1* yrs. mos. ds.

(Signed),

D. W. Jones M. D.
Sept 27, 1915 (Address) *3048 Donnell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Wm. Kearney *Sept 28, 1915**William Jones* *Koslyn Hall*

18-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Mercy Hospital*)

FULL NAME *James H. Parke*

(Residence in Baltimore: No. *1303 James St.*)

ST. *21* WARD

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

7/1/9
(Month)

1
(Day)

1876
(Year)

7-AGE,

39

25

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Videotape

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

MD

10-NAME OF FATHER,

Henry Parke

11-BIRTHPLACE OF FATHER

(State or Country),

Washington DC

12-MAIDEN NAME OF MOTHER

Mary Brewer

13-BIRTHPLACE OF MOTHER

(State or Country),

Washington DC

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Philip L. Parke

(Address)

1303 James St

15-

SEP 28 1915

ROBERT KRAUTER,

Filed

191

Funeral Home Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September

26

1915

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*

(Inquest, autopsy or inquiry.)

and that said deceased came to *his* death

on the day stated above.

The CAUSE OF DEATH was as follows:

suicide - gunshot wound of head

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY

(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Thos. H. Chamber* M. D.

(Coroner.)

Sept. 28, 1915. (Address) *18 St. Francis St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *8 minutes* In the

of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Mercy Hospital

Former or usual residence *1303 James St*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Wood Hill Haven *Sept 29, 1915*

20-UNDERTAKER

W. G. Tinkner & Son

ADDRESS

Remick Valt

10. D.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 C88483

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give his NAME instead of street and number and fill out No. 13.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

SEP 28 1915

ROBERT J. KRAUTER,

Morial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

C88484

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's chft asy* ST. *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Catherine Snow(Residence in Baltimore: No. *St. Vincent's chft asy* St.; yrs. *1* mos. *22* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED, *Single*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Aug *5*, 1915.
(Month) (Day) (Year)

7-AGE,

yrs. *1* mos. *22* ds.If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).*Balt Maryland*

PARENTS.

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

SEP 28 1915

ROBERT J. KRAUTER,

Chief Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept *27*, 1915.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 1st* 1915, to *Sept 26* 1915, that I saw her alive on *Sept 26* 1915 and that death occurred, on the date stated above, at *9:00*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) yrs. *9* mos. *9* ds.CONTRIBUTORY *M. abnutrition*
(Secondary)(Duration) yrs. *1* mos. *9* ds.(Signed) *Robert J. Krauter* M. D.*Sept 27, 1915.* (Address) *1401 Division St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VICARIOUS CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *22* ds. In the State yrs. *1* mos. *22* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *St Vincent's Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Cathedral *Sept 28*, 1915.

20-UNDERTAKER

ADDRESS

Martin Trahey & Sons *106 Lafayette St.*

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* St. *14* WARD)

2-FULL NAME

Pauline Watson

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 10.)

(Residence in Baltimore: No. *St. Vincent's Inf. Asylum* St.; yrs. mos. *24* da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

Aug
(Month)

31st 1915
(Day) (Year)

7-AGE

yrs. *26* ds. or min.?

If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

England

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER
(State or country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *St. Vincent's*

(Address) *1401 Division St.*

15-

SEP 28 1915

ROBERT KRAUTER,

Morial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 26 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 2, 191, to, *Sept 25* 1915,

that I saw h. *er* alive on *Sept 25* 1915,

and that death occurred, on the date stated above, at *5:00* a.m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration) yrs. mos. *26* ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *John L. Luby* M. D.

Sept 27 1915 [Address] *1223 N. Caroline St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *24* ds. State yrs. mos. *26* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *St. Vincent Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral

Sept 28 1915

20-UNDERTAKER

ADDRESS

Martin F. Hayes & Co. 106 Lafayette Ave

HEALTH DEPARTMENT--CITY OF BALTIMORE

C88486

CERTIFICATE OF DEATH

151

C88486

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. *St. Vincent's chft. Asy* St.: *14* WARD)

2-FULL NAME

John Parker

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Vincent's Infant Asylum* St.: yrs. mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*Single*

6-DATE OF BIRTH

Sept
(Month)*11th*
(Day)*1915*
(Year)

7-AGE

yrs. mos. *14* ds. or min.?If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE
(State or country)*Maryland Balb*

PARENTS

10-NAME OF FATHER

*Unknown*11-BIRTHPLACE OF FATHER
(State or country)*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or country)*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

SEP 28 1915

ROBERT J. KRAUTER,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 25, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended decensed from

Sept 12, 1915, to, *Sept 25, 1915*,that I saw him alive on *Sept 25, 1915*,and that death occurred, on the date stated above, at *7.30 P.M.*

The CAUSE OF DEATH* was as follows:

*Malnutrition and
Mal-assimilation*(Duration) yrs. mos. *14* ds.Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *John J. Leubing**Sept 27, 1915* [Address] *1223 N. Caroline St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. *14* ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence *St. Vincent's Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL

Cathedral

DATE OF BURIAL

Sept 28, 1915

20-UNDERTAKER

Martin Fabyan & Co. Baltimore

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88487

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 755 W. Pratt ST. 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME

(Residence in Baltimore: No. 755 W. Pratt St. St. 45 yrs., 1 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Aug. 22, 1870
(Month) (Day) (Year)

7-AGE,

45 yrs., 1 mos., 3 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Shoemaker(b) General nature of industry, business, or establishment in which employed (or employer) At Home

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Guido Krause

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Mary Betzold

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred E. Krause(Address) 755 W. Pratt

15-

SEP 28 1915. ROBERT KRAUTER,
Funeral Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 25, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from September 22, 1915, to September 25, 1915, that I saw him alive on September 24, 1915, and that death occurred, on the date stated above, at 10:00 m. The CAUSE OF DEATH* was as follows:Pulmonary Tuberculosis
(Duration) 6 yrs., 6 mos., 1 ds.

CONTRIBUTORY (Secondary)

Tuberculosis
(Duration) 6 yrs., 6 mos., 1 ds.
(Signed) Albert S. Chambers M. D.
Sept. 24, 1915. (Address) 1012 W. Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 45 yrs., 1 mos., 3 ds. In the State 45 yrs., 1 mos., 3 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Loudon Park

DATE OF BURIAL,

Sept. 28, 1915.

20-UNDERTAKER

Wm Cook

ADDRESS

2016 North

Important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28

C88488

1. PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

2. FULL NAME

(Residence in Baltimore: No.

Sr.

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE MARRIED <i>Married</i> WIDOWED OR DIVORCED (Write the word)
6. DATE OF BIRTH <i>May 15, 1890</i> (Month) (Day) (Year)		
7. AGE <i>25 yrs. 11 mos. 11 ds.</i> If LESS than 1 day, — hrs. or — min.?		
8. OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <i>Stenographer</i>		
9. BIRTHPLACE (State or country) <i>Baltimore</i>		
PARENTS	10. NAME OF FATHER <i>Jos. P. Mercet</i>	
	11. BIRTHPLACE OF FATHER (State or country) <i>Va.</i>	
	12. MAIDEN NAME OF MOTHER <i>Catherine Booth</i>	
	13. BIRTHPLACE OF MOTHER (State or country) <i>Wid.</i>	

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

SEP 28 1915

Filed

191

ROBERT J. KRAUTER

Chief Registrar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept.

26

1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 10, 1915, to Sept 26, 1915,

that I saw him alive on *Sept 26, 1915,*

and that death occurred, on the date stated above, at *8:40 p.m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration)

6 yrs.

mos.

ds

Contributory
(SECONDARY)

Valvular heart disease

(Duration)

unknown yrs.

mos.

ds.

(Signed),

Hugh Forsythe, M.D.

9/28/15, 191

(Address)

4246 North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

Sept 27, 1915

20. UNDERTAKER

ADDRESS

Geo J Smith

Payette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH **Hahnemann General Hospital,**
CITY OF BALTIMORE (No. **1122 N. Mount street,** ST. **16** WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME **Bertha E. Hines,**

(Residence in Baltimore: No. **1201 Winchester st.**

St.; yrs., **Life** mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. **Female,** 4-COLOR OR RACE, **Colored,** 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, **Single,** (Write the word.)

6-DATE OF BIRTH, **January 23d, 1901,** (Month) (Day) (Year)

7-AGE, **14 yrs. 8 mos. 3 ds.** If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, **None,** (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), **Baltimore, Md.**

10-NAME OF FATHER, **Edward A. Hines,** 11-BIRTHPLACE OF FATHER (State or Country), **Virginia,** 12-MAIDEN NAME OF MOTHER, **Lucy J. Freeman,** 13-BIRTHPLACE OF MOTHER (State or Country), **Virginia,**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) **George H. Hines, uncle,** (Address) **1911 N. Brunt street.**

15- **SEP 28 1915** **ROBERT KRAUTER,** Filed....., 191... **Burial Permit Clerk** Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, **September 26th, 1915,** (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an **inquiry** (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said **inquiry** (Inquest, autopsy or inquiry.) and that said deceased came to **her** death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental burns of the 3d degree, caused by dress catching fire at kitchen stove (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) **J. Frederick Campbell** (Duration) **3 yrs. 7 mos. 1 ds.** (Coroner.)

Sept. 27 1915 (Address) **3310 W. North ave.**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. **4** ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? **1201 Winchester street.**

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, **Mt. Auburn Cemetery** DATE OF BURIAL, **Sept 29 1915**

20-UNDERTAKER, **George H. Holland** ADDRESS **517 Robert St.**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Banton Flats*)

2-FULL NAME

Daniel James

(Residence in Baltimore: No. *Not Known*)

ST. *1*

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Not Known*

6-DATE OF BIRTH,

1870
(Month) (Day) (Year)

7-AGE,

45

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Not Known

(b) General nature of industry, business, or establishment in which employed (or employer).

Not Known

9-BIRTHPLACE, (State or Country),

Not Known

10-NAME OF FATHER,

Not Known

11-BIRTHPLACE OF FATHER (State or Country),

Not Known

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER (State or Country),

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-SEP 28 1915

Filed.....

191.....

ROBERT KRAUTER

Chief Registrar

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY.

20-UNDERTAKER Commissioner Health,

Per. Wm. E. WOODALL.

DATE OF BURIAL, SEP 27 1915

ADDRESS

16-DATE OF DEATH,

Sept 12, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-

inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Accidental Drowning

(Duration).....yrs.....mos.....da.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....da.

(Signed).....*David W. Jones* M. D.

(Coroner.)

Sept 26, 1915 (Address) *3116 V. B. Road*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place..... In the of death.....yrs.....mos.....da. State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88491

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 28

C88491

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Maryland Penitentiary* St. *10* WARD)

2-FULL NAME

Arthur Spencer

(Residence in Baltimore: No. *Maryland Penitentiary* St. *1* yrs. *1* mos. *1* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Black

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

May - 31 - 1892
(Month) (Day) (Year)

7-AGE

23 yrs. *3* mos. *17* ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Waiter
Public

9-BIRTHPLACE
(State or country)

Delaware

10-NAME OF FATHER

Benjamin Spencer

11-BIRTHPLACE OF FATHER
(State or country)

Delaware

12-MAIDEN NAME OF MOTHER

Mary Henry

13-BIRTHPLACE OF MOTHER
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. G. ...
MA Penitentiary

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September - 18, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April - 3, 1915*, to, *September - 18, 1915*, that I saw him alive on *September - 18, 1915*, and that death occurred, on the date stated above, at *6.45 p. m.*
The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion

(Duration) yrs. *14* mos. *14* ds.

Contributory (SECONDARY)

Pulmonary Tuberculosis

(Duration) yrs. *5* mos. *15* ds.

(Signed)

William F. Schwartz M. D.

September 19, 1915 [Address] *Maryland Penitentiary*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *2* yrs. *3* mos. *17* ds. In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Sharpsstown, Md.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

PUBLIC CEMETERY

SEP 27 1915

20-UNDERTAKER

Health

ADDRESS

15-

SEP 28 1915

ROBERT KRAUTH
Chief Clerk
REGISTRAR

Wm. E. WOODALL

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
 CITY OF BALTIMORE: (No. *Maryland Hospital 4*) WARD
 2-FULL NAME *Sony McKinley*
 (Residence in Baltimore: No. *Curtis Bay, Md.* St.: yrs., mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, 1
 (Month) (Day) (Year)

7-AGE, *32* yrs. mos. da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Savon*
 (b) General nature of industry, business, or establishment in which employed (or employer). *General*

9-BIRTHPLACE, (State or Country), *Poland*

10-NAME OF FATHER, *unknown*
 11-BIRTHPLACE OF FATHER (State or Country), *"*
 12-MAIDEN NAME OF MOTHER *"*
 13-BIRTHPLACE OF MOTHER (State or Country), *"*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

ROBERT . KRAUTER

Filed. *SEP 28 1915*

Chief Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 16, 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 6, 1915* to *Sept 16, 1915* that I saw him alive on *Sept 16, 1915* and that death occurred, on the date stated above, at *4 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
Operation Sept 5/15
 (Duration).....

CONTRIBUTORY (Secondary).....

(Duration)..... yrs. mos. da.

(Signed)..... M. D.

Sept 22, 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. da. In the State..... yrs. mos. da.

Where was disease contracted, if not at place of death? *Don't know*

Former or usual residence *Curtis Bay, Md.*

19-PLACE OF BURIAL OR REMOVAL

PUBLIC CEMETERY

DATE OF BURIAL

SEP 27 1915

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88493

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No

2-FULL NAME

(Residence in Baltimore: No.

ST. 10 WARD)

St.; yrs. 7 mos. 18 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

SEP 28 1915

ROBERT H. RAUTER

Morial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

May-27, 1915, to September 15, 1915, that I saw him alive on September 15, 1915, and that death occurred, on the date stated above, at 11:40 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Haemorrhage
(Duration) yrs. 2 ds.

Contributory Pulmonary Tuberculosis
(SECONDARY) (Duration) yrs. 3 mos. 19 ds.

(Signed) William F. Schwartz M. D.
9/16/1915 [Address] Md. Penitentiary

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. 7 mos. 18 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Kayser, W. Va.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

PUBLIC CEMETERY

SEP 27 1915

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....

191...

ROBERT J. KRAUTER
Official Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)..... M. D.

Sep. 17., 1915 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. 7 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15-

Filed

ROBERT KRAUTER
Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw h^e alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL
COLLEGE OF P. & S.

DATE OF BURIAL
SEP 27 1915

20-UNDERTAKER

ADDRESS

Per. Wm. E. WOODALL

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88496

CERTIFICATE OF DEATH.

37

C88496

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

614 North Bradford

ST.;

WARD)

2-FULL NAME

Baby Sampson

(Residence in Baltimore: No.

614 North Bradford

St.;

yrs.,

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Single

6-DATE OF BIRTH.

September

26

1915

(Month)

(Day)

(Year)

7-AGE.

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Maryland Balto

PARENTS.

10-NAME OF FATHER,

Sampson, Eugene

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Tenson, Lattie

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John G. Murray Jr. MD

(Address)

Johns Hopkins Hospital

15-

SEP. 28. 1915

ROBERT KRAUTH

Official Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

September

26

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from September 16, 1915, to Sept 26, 1915, that I saw her alive on September 26, 1915, and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Congenital Les

(miscarriage at 6th month)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

John G. Murray Jr.

M. D.

(Address)

Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

COLLEGE OF P. & S.

SEP. 28. 1915

20-UNDERTAKER

Commissioner Health,

ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88497

113

C88497

PLACE OF DEATH

CITY OF BALTIMORE (No. 618 N Washington

ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

John Lyman Nizes (Nizer)

(Residence in Baltimore: No. 618 N Washington

St. 53 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married (Write the word)

6. DATE OF BIRTH

May 6, 1860 (Month) (Day) (Year)

7. AGE

55 yrs. 4 mos. 21 ds. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Fish Dealer

9. BIRTHPLACE (State or country)

Balto. Co. Md

PARENTS

10. NAME OF FATHER

John Nizes

11. BIRTHPLACE OF FATHER (State or country)

Balto. Co. Md

12. MAIDEN NAME OF MOTHER

Ellen Biddison

13. BIRTHPLACE OF MOTHER (State or country)

Balto. Co. Md

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. M. Nizes

(Address)

618 N Washington St.

SEP 28 1915

HARRY O. ANDREWS,
Marial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 27, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 24, 1915, to, Sept 27, 1915.

that I saw him alive on Sept 26, 1915.

and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

(Duration) 1 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

Eugene J. Miller

M. D.

9/27, 1915 (Address) 1818 E. Balto. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

Sept 30, 1915

20. UNDERTAKER

Wm. T. Hartley

ADDRESS

2012 E. Madison St.

C88498

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 N. Straper St ST.; 6 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 103 N. Straper St St.; 30 yrs., — mos., — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-MARITAL STATUS

SINGLE

MARRIED

WIDOWED

(Write the word)

6-DATE OF BIRTH

Sept 19, 1845
(Month) (Day) (Year)

7-AGE

60

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, business, or establishment in which

employed (or employer)

Nursing
Private Family9-BIRTHPLACE,
(State or Country)

Pennsylvania

10-NAME OF FATHER

Unknown

11-BIRTHPLACE OF FATHER
(State or Country)

Pennsylvania

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country)

Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Abram S. Keely

(Address)

103 N. Straper St

15-SEP 28 1915

HARRY O. ANDREWS,

Filed.....

191

Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 27, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Sept 25 1915, to Sept 27 1915,that I saw her alive on Sept 23 1915,and that death occurred, on the date stated above, at 2:45 m.

The CAUSE OF DEATH* was as follows:

Acute - Gastritis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) John J. Quinn M.D.
Sept 27, 1915. (Address) 103 N. Straper St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the..... yrs..... mos..... ds. State.....

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Lorraine Cem

DATE OF BURIAL

Sep 30, 1915

20-UNDERTAKER

William Cook

ADDRESS

502 E North
ave

important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

88499		HEALTH DEPARTMENT--CITY OF BALTIMORE		64		88499	
1 PLACE OF DEATH				CERTIFICATE OF DEATH			
CITY OF BALTIMORE: (No. <u>823 Woodley</u> St. <u>16</u> WARD)				(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)			
2 FULL NAME <u>Lucy C. Bauman</u>							
(Residence in Baltimore: No. <u>823 Woodley St.</u> St. <u>57</u> yrs. <u>9</u> mos. <u>14</u> ds.)							
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widow</u>		13 DATE OF DEATH <u>September 26, 1915</u> (Month) (Day) (Year)			
6 DATE OF BIRTH <u>Jan 14, 1858</u> (Month) (Day) (Year)		7 AGE <u>57</u> yrs. <u>9</u> mos. <u>12</u> ds. or min.?		17 I HEREBY CERTIFY, That I attended deceased from <u>June 9, 1915</u> , to, <u>Sept 26, 1915</u> , that I saw her alive on <u>Sept 26, 1915</u> , and that death occurred, on the date stated above, at <u>2:45 P.</u> m.			
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Housework at home</u>		9 BIRTHPLACE (State or country) <u>Baltimore Md</u>		The CAUSE OF DEATH* was as follows: <u>Apoplexy</u> (Duration) yrs. <u>3</u> mos. <u>11</u> ds.			
10 NAME OF FATHER <u>Friedrich Stanger</u>		11 BIRTHPLACE OF FATHER (State or country) <u>Pa</u>		Contributory (SECONDARY) <u>Paralysis</u> (Duration) yrs. mos. ds.			
12 MAIDEN NAME OF MOTHER <u>Catharine Lauer</u>		13 BIRTHPLACE OF MOTHER (State or country) <u>Pa</u>		(Signed) <u>Joseph E. Bauman</u> M. D. <u>Sept 27, 1915</u> [Address] <u>1520 Hollins St.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Ed. Bauman</u> (Address) <u>823 Woodley St.</u>				* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
15- SEP 28 1915				18 LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS] At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence			
19- PLACE OF BURIAL OR REMOVAL <u>London Park Cem</u>				DATE OF BURIAL <u>Sept 29, 1915</u>			
20- UNDERTAKER <u>John F. Fields 1200 24th St</u>				ADDRESS			

MARY O. ANDERSON
Burial Permit Clerk
REGISTRAR

C88500

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88500

1 CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2435 Mc Culloch

ST.: 13

WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore No. 2435 Mc Culloch

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

63

YRS.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

Manufacturer of
Paste

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Solomon John

11-BIRTHPLACE

OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Solomon Solomon

(Address)

Marlborough St.

SEP 28 1915

HARRY O. ANDREWS,

Filed.....

191

Serial Permit. Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 28

(Month)

(Day)

1915

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration)

unknown

Yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Moses M. Savage

(Coroner)

M. D.

Sept. 28, 1915

(Address)

179 W. Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

of death

Yrs.

mos.

ds.

In the

State

Yrs.

mos.

ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Hebrew

Sept. 30, 1915

20-UNDERTAKER

ADDRESS

J. Andrews & Co

1611 Madison

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If SIGNATURE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION, if very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 723 Cumberland street, ST. 15 WARD)

FULL NAME Warner A. Simmons,

(Residence in Baltimore: No. 723 Cumberland street,

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE. White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single,

6-DATE OF BIRTH, April 18th, 1880. (Month) (Day) (Year)

7-AGE, 35 yrs., 5 mos., 9 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Clerk, (b) General nature of industry, business, or establishment in which employed (or employer). Liquor store,

9-BIRTHPLACE. (State or Country), Baltimore, Md.

10-NAME OF FATHER, Thomas W. Simmons,

11-BIRTHPLACE OF FATHER (State or Country), Maryland,

12-MAIDEN NAME OF MOTHER Annie Heaps,

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Simmons, mother,

(Address) 723 Cumberland street,

SEP 29 1915. ROBERT KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 27th, 1915. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. (Inquest, su-

inquiry find that said deceased came to his death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis,

(Duration) yrs. mos. ds.

CONTRIBUTORY Chronic alcoholism, (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Heaps, M. D. (Coroner.)

Sept. 27, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

M. E. Cemetery Risterstown Sept 30, 1915

20-UNDERTAKER, ADDRESS

Isiah Syfer 1600 N. North Ave

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 512 Mc Nechem St. 14 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and RR cut No. 18.)

2-FULL NAME David Elton Walker

(Residence in Baltimore: No. 512 Mc Nechem St. - yrs. - mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE col. 5-SINGLE single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH Sep. 24, 1915
(Month) (Day) (Year)

7-AGE - yrs. - mos. 5 ds. or 1 day, - hrs., - min.?

8-OCCUPATION None
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balt. ind.

10-NAME OF FATHER David Elton Walker

11-BIRTHPLACE OF FATHER (State or country) Virginia

12-MAIDEN NAME OF MOTHER Elizabeth Nyatt

13-BIRTHPLACE OF MOTHER (State or country) Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. M. Barnes

(Address) 507 W. Hoffman

15-SEP 29 1915

191

ROBERT J. KRAUTH

Morial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sep. 28, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep 24, 1915, to, Sep. 28, 1915, that I saw him alive on Sep. 28, 1915, and that death occurred, on the date stated above, at 2:30 p.m. The CAUSE OF DEATH* was as follows:

Ileo-colitis

Contributory (SECONDARY) Improper feeding (Duration) yrs. mos. ds.

(Signed) Edw. J. Whalley M. D. Sep. 28-15 [Address] 1720 Druid Hill Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Laurel Cemetery Sep 29, 1915

20-UNDERTAKER ADDRESS

John A. T. Bishop 5 Hill Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1750 Bank ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1750 Bank St. St.: Life mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH

Jan, 1867
(Month) (Day) (Year)

7-AGE

48 yrs. 8 mos. da.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE, (State or Country).

Balta Md

10-NAME OF FATHER

Redmond Lewis

11-BIRTHPLACE OF FATHER (State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER (State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Alice Cleary

(Address)

1750 Bank St.

15-

SEP 29 1915

ROBERT

KRAUTHR

BIRTHAL. P. M. T. C. C. V

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 28th, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 7, 1915, to Sept 28, 1915, that I saw her alive on Sept 27, 1915, and that death occurred, on the date stated above, at 4:00 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Pulmonary Tuberculosis(Duration) 1 yrs. 1 mos. 1 da.

CONTRIBUTORY (Secondary)

Cardiac Exhaustion(Duration) 1 yrs. 1 mos. 1 da.

(Signed)

A. L. Gumbleton M. D.Sept. 28, 1915 (Address) 2013 Bank St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 1 mos. 1 da. In the State 1 yrs. 1 mos. 1 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St Patrick

DATE OF BURIAL

Sept 30th, 1915

20-UNDERTAKER

John A Moran

ADDRESS

Bank St

COPIES OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

11-8. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 506 Prossman St. 14 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Pleasant Hill
(Residence in Baltimore: No. 506 Prossman St. 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Blond 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed
6-DATE OF BIRTH Unknown 18 58 (Month) (Day) (Year)
7-AGE 57 yrs. mos. ds. or min. If LESS than 1 day, hrs., min.?
8-OCCUPATION (a) Trade, profession or particular kind of work Porter (b) General nature of industry, business, or establishment in which employed (or employer) Bank
9-BIRTHPLACE (State or country) Va

PARENTS
10-NAME OF FATHER Joseph Hill
11-BIRTHPLACE OF FATHER (State or country) Va
12-MAIDEN NAME OF MOTHER Sarah Hill
13-BIRTHPLACE OF MOTHER (State or country) Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Viola Hill
(Address) 506 Prossman

15-ROBERT KRAUTER, Registrar
SEP 29 1915 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept 27 1915 (Month) (Day) (Year)
17-I HEREBY CERTIFY, That I attended deceased from March 27, 1915, to Sept 27, 1915, that I saw him alive on Sept 27, 1915, and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

General Arterio-sclerosis
(Duration) 1 yrs 6 mos. ds.
Contributory (SECONDARY) Renal cirrhosis
(Duration) 6 yrs 6 mos. ds.
(Signed) H. S. McLeod M.D.
9/28, 1915 (Address) 7005 2nd Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Laurel Lane
DATE OF BURIAL 9/29 1915
20-UNDERTAKER Samuel J. Hunsby
ADDRESS 578 N. Biddle

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C.

CITY OF BALTIMORE: (No. 409 Millington Lane St.: 20 WARD)

2-FULL NAME Wilbur Morgan Enos

(Residence in Baltimore: No. 409 Millington Lane St.: 20 yrs. 2 mos. 6 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male

4-COLOR OR RACE White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) Single

6-DATE OF BIRTH July 22, 1915

(Month) (Day) (Year)

7-AGE 2 yrs. 6 mos. 6 ds. or min.?

If LESS than
1 day, hrs.,
min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Child

9-BIRTHPLACE (State or country) Baltimore Md.

10-NAME OF FATHER Frank Enos

11-BIRTHPLACE OF FATHER (State or country) Maryland

12-MAIDEN NAME OF MOTHER Willa Marsh

13-BIRTHPLACE OF MOTHER (State or country) Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. S. Enos

(Address) 409 Millington Lane

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept 28, 1915

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 18, 1915, to Sept 28, 1915,

that I saw him alive on Sept 26, 1915, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Marasmus

Contributory (SECONDARY)

(Duration) yrs. mos. ds. 20 ds.

(Signed) William L. Buggert M. D.

(Duration) yrs. mos. ds. 3 ds.

9/28/15, 191 (Address) 2108 N. Fulton Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Int. Christ

DATE OF BURIAL Sept. 29

20-UNDERTAKER Geo L. Schmatz & Co

ADDRESS 2108 N. Fulton Ave

15-SEP 29 1915

ROBERT KRAUTER

Filed 29, 191

Official Permit Officer REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 E Mt Vernon Place ST. 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Victor Smith(Residence in Baltimore: No. 22 E Mt. Vernon Place St. 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Feb51848

(Month)

(Day)

(Year)

7-AGE,

677

yrs. mos. ds.

8-LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Lawyer

9-BIRTHPLACE,

(State or Country),

Savannah Ga

10-NAME OF FATHER,

M. L. Smith

11-BIRTHPLACE OF FATHER

(State or Country),

N.Y. State

12-MAIDEN NAME OF MOTHER

Sarah Nisbet

13-BIRTHPLACE OF MOTHER

(State or Country),

Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edgeworth Smith

(Address)

22 E Mt. Vernon Pl.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 28281915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

1913to Sept 281915that I saw him alive on Sept 28 1915,and that death occurred, on the date stated above, at 4:20 m.

The CAUSE OF DEATH* was as follows:

Circumference of the Larynx(Radical Cure)(Duration).....yrs. 10 mos. ds.

CONTRIBUTORY

(Secondary)

(Duration).....yrs. mos. ds.

(Signed).....Wm. A. Brown M. D.Date 21, 1915. (Address).....194 B. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenmount CemeterySept 30, 1915.

20-UNDERTAKER

Henry H. Jenkins & Sons Co. 1214 E. St.

15-SEP 29 1915

Filed.....1915

ROBERT J. KRAUTH

Bureau Permit Clerk

Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 Brentwood Ave ST.; 10 WARD)

REGISTERED NO. C

2-FULL NAME

Irene Ruth Mercer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1032 Brentwood Ave St.; 1 yrs., 9 mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH

Dec 29, 1913
(Month) (Day) (Year)

7-AGE

1 yrs., 9 mos., — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None9-BIRTHPLACE,
(State or Country),Balto. Md.

10-NAME OF FATHER,

Stanley H. Mercer

11-BIRTHPLACE OF FATHER

(State or Country),

Balto. Md.

12-MAIDEN NAME OF MOTHER

Louise Knoodler

13-BIRTHPLACE OF MOTHER

(State or Country),

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mother (Louise Mercer)

(Address)

1032 Brentwood Ave

15-

SEP 29 1915

Filed

ROBERT

KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 29, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 23rd 1915, to Sept 29th 1915,that I saw her alive on Sept 29 1915, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Gastric Enteritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

Sept 29, 1915 (Address) 219 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

Holy Redeemer Cemetery

DATE OF BURIAL,

Sept 30, 1915

20-UNDERTAKER

Henry Strep

ADDRESS

1301 E. Eagerth

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 Bayard ST. 41 WARD)

2-FULL NAME

(Residence in Baltimore: No. 913 Bayard St.; Lafayette ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, June 18, 1879
(Month) (Day) (Year)

7-AGE, 36 yrs. 3 mos. 10 ds. If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... *House Suits*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE.
(State or Country), *Balto. Ind.*

10-NAME OF FATHER, *Conrad Fink*

11-BIRTHPLACE
OF FATHER
(State or Country). *Germany*

12-MAIDEN NAME
OF MOTHER *Kathleen M. [illegible]*

13-BIRTHPLACE
OF MOTHER
(State or Country), *Germany.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Roman

(Address) 913 Bayard

15- 057 0 0 1015 ROBERT . KRAUTH:

SEP 29 1945

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
July 3 1915, to Sept 27 1915,
that I saw her alive on Sept 27 1915,
and that death occurred, on the date stated above, at 6:40 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mon.....da.
(Signed) James I. Huff M. D.
Sept 28, 1915 (Address) Washington, D. C.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mo. da. In the State yrs. mo. da.

Where was disease contracted,
if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
1. <i>1000</i>	<i>1000</i>
2. <i>1000</i>	<i>1000</i>
3. <i>1000</i>	<i>1000</i>
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London Park Cem. S. F. 1., 191.

20-UNDERTAKER	ADDRESS
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44 Mrs. John H. Sump 801 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 N. Saratoga ST. 20 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1932 N. Saratoga St.; 58 yrs., — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) Married

6-DATE OF BIRTH,

Oct. 15th, 1839
(Month) (Day) (Year)

7-AGE,

75 yrs. 11 mos. 12 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country), Germany

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country) Germany

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine M. Helenberg(Address) 1932 N. Saratoga St.

15-SEP 29 1915

ROBERT KRAUTER

Filed.....

191

Serial Permit 0107

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 27th, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Dec 15, 1914, to Sept 27, 1915that I saw him alive on Sept 27, 1915and that death occurred, on the date stated above, at 6:15 m.

The CAUSE OF DEATH* was as follows:

Acute Lobular Pneumonia
of left lung(Duration) yrs. mos. 3 ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. H. H. M. D.9/28/15 191... (Address) 1725 Hollis

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery Sept 30, 1915

20-UNDERTAKER

ADDRESS

Mrs. John W. Seufel 801 N. Bayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT CITY OF BALTIMORE

C88511

CERTIFICATE OF DEATH

76 C88511

1-PLACE OF DEATH

Balto. Eye and Throat Hosp.

REGISTERED NO. C

CITY OF BALTIMORE (No.

625 N. Frankline St.

WARD

2-FULL NAME

Mrs. Mollie T. Bagger

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1212 N. Pratt St.

68 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6-DATE OF BIRTH Oct 19, 1846 (Month) (Day) (Year)

7-AGE 68 yrs. 11 mos. 9 ds. or less than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE (State or country) Va

10-NAME OF FATHER John Burns

11-BIRTHPLACE OF FATHER (State or country) Va

12-MAIDEN NAME OF MOTHER Kate Oney

13-BIRTHPLACE OF MOTHER (State or country) Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Bearden

(Address) 904 31/2 Fayette

15. SEP 29 1915 ROBERT KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept 28, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1915, to Sept 28, 1915, that I saw him alive on Sept 27, 1915, and that death occurred, on the date stated above, at 7 A. M. The CAUSE OF DEATH* was as follows:

Cerebral - Abscess

2 (Duration) yrs. mos. ds.

Contributory (SECONDARY) Malaria (Duration) ? yrs. mos. ds.

(Signed) J. J. O'Donoghue M. D. Sept 28, 1915 (Address) 529 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 9 ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence 1212 N. Pratt St.

19-PLACE OF BURIAL OR REMOVAL Bunnia Vista Va DATE OF BURIAL Sept 29, 1915

20-UNDERTAKER John Fields 12004 Pauland St ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88512

C88512

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

Feb.

29.

1914

(Month)

(Day)

(Year)

7-AGE.

1

6

28

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country).

Baltimore

10-NAME OF FATHER.

Adam Gialkowski

11-BIRTHPLACE OF FATHER (State or Country).

Poland

12-MAIDEN NAME OF MOTHER.

Walerya Szuszkonski

13-BIRTHPLACE OF MOTHER (State or Country).

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Adam Gialkowski

(Address).

2039 Fleet St.

15-

SEP 29 1915

Filed

191

ROBERT KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept. 27, 1915.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 20 1915, to Sept 27 1915,

that I saw him alive on Sept 27 1915,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Bronch. Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

Sept 27, 1915 (Address) 185 Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Rosary

Sept. 28, 1915.

20-UNDERTAKER

ADDRESS

Jacob Gialkowski 428 S Bond St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88513

CERTIFICATE OF DEATH.

152 C88513
REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Infant Treacock*(Residence in Baltimore: No. *University Hospital* St.: 0 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word)*Single*

6-DATE OF BIRTH.

Sept. 28, 1915
(Month) (Day) (Year)

7-AGE.

*0 yrs. 0 mos. 0 ds.*If LESS than 1 day,
0 hrs. or 30 min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer)*None*
*None*9-BIRTHPLACE,
(State or Country),*Maryland*10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

SEP 29 1915

ROBERT . KRAUTER

Mort. Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

9-28, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
*1-28, 1915, to 9-28, 1915.*that I saw him alive on *9-28, 1915,*
and that death occurred, on the date stated above, at *6 A. m.*

The CAUSE OF DEATH* was as follows:

Congenital Ataxia
(Duration) *0 yrs. 0 mos. 0 ds.*CONTRIBUTORY
(Secondary)*Prematurity*
(Duration) *0 yrs. 0 mos. 0 ds.*
(Signed) *P. B. Rush* M. D.
7-28, 1915 (Address) *Univ. (Kary)**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

UNIVERSITY OF MARYLAND
SEP 29 1915

20-UNDERTAKER

Commissioner Health.

ADDRESS

Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 N. Payson ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 932 N. Payson St St.; 40 yrs., 3 mos., 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widowed
(Write the word.)

6-DATE OF BIRTH.

June 23, 1875
(Month) (Day) (Year)

7-AGE.

40 yrs., 3 mos., 5 ds.IF LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Printer
General job printing9-BIRTHPLACE.
(State or Country).Baltimore

10-NAME OF FATHER.

John A. Whitney11-BIRTHPLACE OF FATHER
(State or Country).Baltimore

12-MAIDEN NAME OF MOTHER

Sarah E. Connor13-BIRTHPLACE OF MOTHER
(State or Country).Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Whitney(Address) 932 N. Payson St.

15 SEP 29 1915

HUBERT KRAUTER

Filed..... 191.....
Registral. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

September 28, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from August 7 1915, to Sept 28 1915, that I saw him alive on Sept 18 1915, and that death occurred, on the date stated above, at 8:15 m. The CAUSE OF DEATH* was as follows:Pulmonary tuberculosis
(Duration).....yrs....1....mos....21....ds.CONTRIBUTORY
(Secondary)(Signed) Geo. T. Kemp M. D.
Sept 28, 1915. (Address) St. James Appartment

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Louisa (Fort. Gen.) Sept 29, 1915.

20-UNDERTAKER

John Rowan & Son 901 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88515

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88515

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

St.; 11 yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.,
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

PARENTS

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from
1915, to, 1915,
that I saw him alive on 1915,
and that death occurred, on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, 3 yrs. 9 mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

16-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

SEP 29 1915

HARRY O. ANDREWS,
Serial Permit Clerk
REGISTRAR

Cathedral Cemetery
Geo. H. Holland

Sept 20, 1915
Robert St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88516

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88516

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *1010 W Pratt* ST.: *18* WARD)

2-FULL NAME *Michael McKeever*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

(Residence in Baltimore: No. *1010 W Pratt st* St.: *18* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

Married

Widowed

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

Unknown

7-AGE

81

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

retiree
Railroad laborer

9-BIRTHPLACE
(State or country)

Ireland

10-NAME OF FATHER

John McKeever

11-BIRTHPLACE OF FATHER
(State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Alice Monahan

13-BIRTHPLACE OF MOTHER
(State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. M. Riley

(Address)

1813 W Baltimore St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September 28, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 20, 1915, to, Sept 28, 1915,

that I saw him alive on *Sept 27, 1915,*

and that death occurred, on the date stated above, at *5:00* p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)

yrs

mos

ds

Contributory
(SECONDARY)

Pneumonia

(Duration)

yrs

mos

ds

(Signed)

Joseph E. Moore

M. D.

Sept 27, 1915 [Address] *1813 W Baltimore St*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs

mos

ds

In the

yrs

mos

ds

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral Ave

Sept 30, 1915

20-UNDERTAKER

ADDRESS

Joseph B. Cook

1003 W Balto St

SEP 29 1915

HARRY O. ANDREWS,
Sanial Permit Clerk,
REGISTRAR

88517

HEALTH DEPARTMENT—CITY OF BALTIMORE

88517

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Marcus Westcott*(Residence in Baltimore: No. *Belair M.D.* St. *—* yrs. *—* mos. *8* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

Unknown, 1872

7-AGE,

43 yrs. *—* mos. *—* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

General

9-BIRTHPLACE, (State or Country),

Maryland

PARENTS.

10-NAME OF FATHER,

Wah Westcott

11-BIRTHPLACE OF FATHER (State or Country),

Maryland.

12-MAIDEN NAME OF MOTHER

Annie King

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *H. O. Andrews*(Address) *Belair M.D.*

15-SEP 29 1915

HARRY O. ANDREWS,

Filed....., 191...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 29, 1915

17-I HEREBY CERTIFY, That I attended deceased from

*Sept 21, 1915, to Sept 29, 1915*that I saw him alive on *Sept 29, 1915*,and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

Potts Disease & Pulch. Meningitis.
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Elmer H. Henshaw, M.D.**Sept 29, 1915.* (Address) *University Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the *43* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Belair M.D.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Belair M.D.**Sept 29, 1915.*

20-UNDERTAKER

ADDRESS

*W. J. Hayes**514 Wilshire*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3008 Windsor ave* ST. *15* WARD)

2-FULL NAME *Minnie H. Wonders*

(Residence in Baltimore: No. *3008 Windsor ave* St. *4* yrs. *4* mos. *4* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE MARRIED *Married* WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH *Nov. 21, 1862* (Month) (Day) (Year)

7-AGE *52* yrs. *10* mos. *7* ds. or min. If LESS than 1 day, hrs. min.?

8-OCCUPATION (a) Trade, profession or particular kind of work *none* (b) General nature of industry, business, or establishment in which employed (or employer) *Housewife*

9-BIRTHPLACE (State or country) *Pennsylvania*

10-NAME OF FATHER *Andrew Brumohl*

11-BIRTHPLACE OF FATHER (State or country) *Pennsylvania*

12-MAIDEN NAME OF MOTHER *Catherine Brumohl*

13-BIRTHPLACE OF MOTHER (State or country) *Pennsylvania*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Edwin H. Wonders*

(Address) *3008 Windsor ave*

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH *Sept 28, 1915* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *April 10th, 1915* to *Sept 28th, 1915*, that I saw her alive on *Sept 27th, 1915*, and that death occurred, on the date stated above, at *2 a.m.* The CAUSE OF DEATH* was as follows:

Haemorrhage Caused (Duration) *one* yrs. *0* mos. *0* ds.

Contributory (SECONDARY) *None* (Signed) *E. H. Wonders* M. D. (Address) *104 S. E. 10th St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Edgemoor Cemetery* DATE OF BURIAL *Sept 30, 1915*

20-UNDERTAKER *Edgemoor Cemetery* ADDRESS *Edgemoor Cemetery*

SEP 29 1915

HARRY O. ANDREY

MARITAL PERMIT CLERK

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88520

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Lohrs Lane* ST.; *20* WARD)2-FULL NAME *Attilio Ciambroschini*(Residence in Baltimore: No. *Lohrs Lane near Clamont* St.; *5* yrs., *5* mos., *5* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *Dec 1 1917*

(Month)

(Day)

(Year)

7-AGE, *17 yrs. 9 mos. 5 ds.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Cashier*(b) General nature of industry, business, or establishment in which employed (or employer) *General*9-BIRTHPLACE, (State or Country), *Italy*10-NAME OF FATHER, *Antonio Ciambroschini*11-BIRTHPLACE OF FATHER (State or Country), *Italy*12-MAIDEN NAME OF MOTHER *Pollina Caserta*13-BIRTHPLACE OF MOTHER (State or Country), *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

SEP 29 1915 HARRY O. ANDREWS, REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *September 29 1917*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 22 1917* to *Sept 29 1917*that I saw h *alive* on *Sept 29 1917*and that death occurred, on the date stated above, at *5* m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *New Cathedral*DATE OF BURIAL, *Sept 30 1917*20-UNDERTAKER *Charles W. Hill*ADDRESS *3109 Fred Ave*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88521

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *2021 Frederick Ave.*)

ST. *20* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Corinne Schwalb.

(Residence in Baltimore: No. *2021 Frederick Ave.*)

St. *28* yrs. *1* mos. *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female.

4-COLOR OR RACE

White.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married.

6-DATE OF BIRTH

August 10th, 1887.
(Month) (Day) (Year)

7-AGE

28 yrs. *1* mos. *18* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework.

9-BIRTHPLACE

(State or country)

Balto. Md.

10-NAME OF FATHER

Max. Von Schoren.

11-BIRTHPLACE OF FATHER

(State or country)

Germany.

12-MAIDEN NAME OF MOTHER

Martha Henning.

13-BIRTHPLACE OF MOTHER

(State or country)

Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry F. Schwalb.

(Address)

2021 Frederick Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 28, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 8*, 1915, to *Sept 28*, 1915,

that I saw him alive on *Sept 28*, 1915, and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory (SECONDARY)

Exhaustion
(Duration) *1* yrs. *10* mos. ds

(Signed) *Arthur Henning* M. D.
Sept 29, 1915. (Address) *2000 Hollins St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park.

DATE OF BURIAL

Oct. 1st, 1915.

20-UNDERTAKER

Geo. L. Schwalb & Bro. 2101 Fred'k Ave.

ADDRESS

SEP 29 1915

Filed, 191

HARRY O. ANDERSON,
Barial Permit Clerk

REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 27 S. Duncan ST.: 1 WARD)
2-FULL NAME Child of Wilbert & Edna Rossbury
(Residence in Baltimore: No. 27 S. Duncan)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 9 mos. hours ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, Colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
(Write the word.)
6-DATE OF BIRTH, Sept 28, 1915
(Month) (Day) (Year)
7-AGE, 9 yrs. 9 mos. 9 hrs. or 9 min.
If LESS than 1 day,
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer), None

9-BIRTHPLACE, (State or Country), Baltimore
PARENTS.
10-NAME OF FATHER, Wilbert Rossbury
11-BIRTHPLACE OF FATHER (State or Country), Baltimore
12-MAIDEN NAME OF MOTHER, Edna Jones
13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edna Rossbury
(Address) 27 S. Duncan St.

15-SEP 29 1915
Filed....., 191.....
HARRY C. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28, 1915
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, and that said deceased came to his death on the day stated above.
(Inquest, autopsy or inquiry.)
The CAUSE OF DEATH* was as follows:

Alatosis Nervatorum
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)
(Duration)..... yrs..... mos..... ds.
(Signed) D. W. Jones M. D.
(Coroner)
Sept 29 1915 (Address) 3116 Oldenell St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem DATE OF BURIAL, Sept 30, 1915

20-UNDERTAKER, Harry A. Voderly ADDRESS 1725 Orleans St

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.;

yrs.

mos.

da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Chief

6-DATE OF BIRTH.

Sept

23rd

1907

(Month)

(Day)

(Year)

7-AGE.

8

yrs.

-

mon.

6

da.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Home

9-BIRTHPLACE,

(State or Country),

Balto Md

10-NAME OF FATHER,

Wm Holmes

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Katie Ashline

13-BIRTHPLACE OF MOTHER (State or Country),

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm Holmes

(Address)

1615 Mulikin St

SEP 29 1915

HARRY O. ANDREWS,

Burial Permit Clerk.

Filed.....

101.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

28

1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

Sept 22

1915

, to

Sept 28

1915

that I saw him alive on

Sept 27

1915

and that death occurred, on the date stated above, at

3450

m.

The CAUSE OF DEATH* was as follows:

Coronary Spasmodic
affection and
apoplexy (Duration) yrs. mos. 5. da.

CONTRIBUTORY (Secondary)

apoplexy (Duration) yrs. mos. 5. da.

(Signed) Dr. J. H. Kempman, M. D.

Sept 28, 1915 (Address) 708 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Mt Zion Cem.

Sept 30 1915

20-UNDERTAKER

ADDRESS

Harry A. Hodery

1725 Orleans St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *8 N Pine* ST. *4* WARD)
2-FULL NAME *Elizabeth Gable*
(Residence in Baltimore: No. *8 N. Pine* St. *1* yrs. *8* mos. *-* ds.)

REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*
6-DATE OF BIRTH *Aug. 26, 1832*
(Month) (Day) (Year)
7-AGE *83* yrs. *8* mos. *26* ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION *Housewife*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE *Germany*
(State or country)

10-NAME OF FATHER *Fredk Gable*

11-BIRTHPLACE OF FATHER *Germany*
(State or country)

12-MAIDEN NAME OF MOTHER *Gable*

13-BIRTHPLACE OF MOTHER *Germany*
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Fredk Gable*
(Address) *8 N Pine St.*

15-SEP 30 1915
ROBERT . KRAUTH
Morial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept. 28, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Sept 15, 1915* to *Sept 28, 1915*, that I saw her alive on *Sept 28, 1915*, and that death occurred, on the date stated above, at *8 P.* m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Arterio Sclerosis
Septicemia
(Duration) *3* yrs. *-* mos. *-* ds.
Contributory *Cardiac Asthenia*
(SECONDARY) (Duration) *5* yrs. *-* mos. *-* ds.
(Signed) *J. A. Meade* M. D.
(Address) *1530 M. Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death *-* yrs. *-* mos. *-* ds. In the State *-* yrs. *-* mos. *-* ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Woodlawn* DATE OF BURIAL *Sept 30*
20-UNDERTAKER *Robt T. Turner* ADDRESS *1422 N. E.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *St Peter's Cemetery* ST. *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St Peter's Cemetery* St. *60* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

April

(Month)

1

(Day)

1842

(Year)

7-AGE,

73

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country).

Ireland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Ellen Murphy

13-BIRTHPLACE OF MOTHER (State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Thomas E. Sands

(Address)

St Peter's Cemetery City

15-SEP 30 1915

Filed..... 191.....

ROBERT J. KRAUTER

Municipal Health Officer

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

(Month)

28

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 21 1915, to *Sept 28 1915*,that I saw her alive on *Sept 27 1915*,and that death occurred, on the date stated above, at *6:40 am*

The CAUSE OF DEATH* was as follows:

General debility

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cardiac Weakness

(Duration)..... yrs. mos. ds.

(Signed)..... *A. D. Driscoll*..... M. D.*Sept 30, 1915* (Address)..... *312 N Carrollton St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St Peter's**19.....1...., 1915.*

20-UNDERTAKER

ADDRESS *517 N**Hannys B. ...*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 2654 Florence St. 13 WARD)
2-FULL NAME Harry Smith
(Residence in Baltimore: No. 2650 Florence St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 50 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>male</i>	4-COLOR OR RACE, <i>colored</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>Married</i>
6-DATE OF BIRTH, <i>12-1-1901</i>		
7-AGE, <i>75</i>	If LESS than 1 day, ...hrs. or...min.?	
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Waiter</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>Public</i>		

PARENTS.	9-BIRTHPLACE, (State or Country),	Maryland
	10-NAME OF FATHER,	unknown
	11-BIRTHPLACE OF FATHER (State or Country),	Long Green Md
	12-MAIDEN NAME OF MOTHER	unknown
	13-BIRTHPLACE OF MOTHER (State or Country),	unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William H Smith
(Address) 938 Mason St

SEP 30 1915

ROBERT . BRAUTER

Filed..... 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept- 28, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy & inquiry) thereon and, from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH was as follows:

CONTRIBUTORY
(Secondary)

(Signed) Harry E. Blair (Duration) 14 mos. 14 ds.
M. D. 5-29-79 (Coron) 5
101 (Address) 3640 Colman Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place _____ In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.
National Cemetery

DATE OF BURIAL,
Oct 1, 1918

24-UNDERTAKER

Peter B. Gye

ADDRESS

1026. Malbury

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88527

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

132

C88527

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *320 N Stricker* ST. *19* WARD)

2-FULL NAME *Mrs Emma L Cole*

(Residence in Baltimore: No. *320 N Stricker* St. *L* yrs. *4* mos. *2* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *Married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Feb 6th 1870*
(Month) (Day) (Year)

7-AGE *45* 7 22 If LESS than
1 day, hrs.,
yrs. mos. ds. or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *House wife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Md Balto*

10-NAME OF FATHER *Thos J Christopher*

11-BIRTHPLACE OF FATHER (State or country) *Md.*

12-MAIDEN NAME OF MOTHER *Elizabeth Hannon*

13-BIRTHPLACE OF MOTHER (State or country) *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Christopher*
(Address) *1935 N Fulton St*

15- *SEP 30 1915* ROBERT KRAUTER
Serial Permit Uler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept 28th 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Sept 15th 1915*, to, *Sept 28th 1915*, that I saw her alive on *Sept 28th 1915*, and that death occurred, on the date stated above, at *7:00* m.

The CAUSE OF DEATH* was as follows:

Peritonitis

Contributory (SECONDARY) *Enlarged liver tube & fibrous changes*
Robert A Mortimer
Sept 30 1915 [Address] *530 N Fulton*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20-UNDERTAKER ADDRESS

Wister
Ger. S. Lillies 311 N. Mount St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 802 W. Franklin street, ST. 17 WARD)

2-FULL NAME

Elizabeth Woelfe,

(Residence in Baltimore: No.

802 W. Franklin street,

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female,

4-COLOR OR RACE,

White,

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single,

6-DATE OF BIRTH,

September 6th, 1915.

(Month)

(Day)

(Year)

7-AGE,

0 yrs. 0 mos. 23 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION;

(a) Trade, profession, or particular kind of work.

None,

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

George Woelfe,

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Minnie Pretall,

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Woelfe, mother,

(Address) 802 W. Franklin street,

15-

SEP 30 1915

ROBERT KRAUTH,

Filed....., 191

Marshall Paralel Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 29th, 1915.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.

inquiry (Inquest, au-

and that said deceased came to her death

topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Atelectasis,

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner.)

Sept. 30, 1915, (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88529

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88529

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1903 W. Fayette*

2-FULL NAME *Carrie Calbert*

(Residence in Baltimore: No. *1031 Booth*

ST. *18*

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

44 43.

St.: yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Unknown, 1863
(Month) (Day) (Year)

7-AGE,

52

yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housework at home

9-BIRTHPLACE,

(State or Country),

Md

10-NAME OF FATHER,

James Short

11-BIRTHPLACE OF FATHER

(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Susie Gray

13-BIRTHPLACE OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Susie Jackson*

(Address) *682 George St.*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 27, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*, au-

Inquiry and that said deceased came to *her* death
topsy or inquiry on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris
(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) *Samuel H. Bunker* M. D.
(Coroner.)

Sept. 28, 1915 (Address) *2302 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Andrew's *Sept. 28, 1915*

UNDERTAKER

ADDRESS

James H. Quinn *133 Reisterstown*

15-

SEP 30 1915

ROBERT KRAUTER

Marital Permit Clerk

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Protestant Infirmary* ST.; *12* *Dinner St.* WARD)

REGISTERED NO. C

2-FULL NAME *Col. Albert B. Cunningham*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *2241 Barclay St.* St.; *69* yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widowed* (Write the word.)6-DATE OF BIRTH, *Nov 10, 1845* (Month) (Day) (Year)7-AGE, *69* yrs., *11* mos., *10* ds. If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Judge*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Louisiana*10-NAME OF FATHER, *John H. Cunningham*11-BIRTHPLACE OF FATHER (State or Country), *S.C.*12-MAIDEN NAME OF MOTHER *Miss Anne Bowie*13-BIRTHPLACE OF MOTHER (State or Country), *Miss.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Otto E. Utzinger*(Address) *Union Prot. Infirmary*

SEP 30 1915

Filed

191

H. BERT KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 29, 1915* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 16* 1915, to *Sept 29* 1915, that I saw him alive on *Sept 29*, 1915, and that death occurred, on the date stated above, at *3 P. m.*

The CAUSE OF DEATH* was as follows:

Inoperable carcinoma, probably of the sigmoid(Duration) *1* yrs., *7* mos., *7* ds.CONTRIBUTORY (Secondary) *Pneumonia*(Duration) *10* yrs., *10* mos., *10* ds.(Signed) *Otto E. Utzinger* M. D.*Sept 29, 1915* (Address) *Union Prot. Infirmary*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs., *11* mos., *10* ds. In the State *1* yrs., *11* mos., *10* ds.Where was disease contracted, if not at place of death? *Baltimore, Md.*Former or usual residence *Baltimore, Md.*19-PLACE OF BURIAL OR REMOVAL, *London Park Cemetery*DATE OF BURIAL, *Oct. 1st, 1915*20-UNDERTAKER *Henry H. Jenkins & Sons Co**Richard St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE CAREFULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St. Joseph's Hospital* 10 WARD
CITY OF BALTIMORE (No. *St. Joseph's Hospital* ST. 10 WARD)
2-FULL NAME *Charles H. Giles*
(Residence in Baltimore: No. *917 Hillman St* St.; yrs. 40 mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
4-COLOR OR RACE, *Colored*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)
6-DATE OF BIRTH, *Unknown*, 1
(Month) (Day) (Year)

7-AGE, *40* yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balto Md*

10-NAME OF FATHER, *Charles H. Giles*

11-BIRTHPLACE OF FATHER (State or Country), *Md*

12-MAIDEN NAME OF MOTHER, *Johanna Pring*

13-BIRTHPLACE OF MOTHER (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Minie J. Brown*
(Address) *1001 Ontario St*

15- *ROBERT KRAUTER*
Filed *SEP 30 1915* Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 28*, 191*5*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquiry*
(Inquest, autopsy or inquiry.)
and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Thaemia (Thaemic Convulsions)

CONTRIBUTORY (Secondary) *Nephritis*
(Duration) yrs. mos. ds.

(Signed) *Oliver J. Russell* M. D.
(Coroner)
Sept 29 1915 (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the *40* yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence *917 Hillman St*

19-PLACE OF BURIAL OR REMOVAL, *Forest Cemetery*

20-UNDERTAKER, *Chas E Bailey*

DATE OF BURIAL, *Oct 1st*, 191*5*

ADDRESS *Jefferson St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 N. Fulton Ave.

ST.:

REGISTERED No. C

WARD) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillie M. Holmes

(Residence in Baltimore: No. 2125 N. Fulton Ave.

St. Lifetime yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
 4-COLOR OR RACE, White
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Jan. 5th. 1866.
 (Month) (Day) (Year)

7-AGE, 49 yrs. 8 mos. 21 ds.
 If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, Housekeeper
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, George W. Beard

11-BIRTHPLACE OF FATHER (State or Country), Penna.

12-MAIDEN NAME OF MOTHER, Elmira Cronbie

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Marie Holmes

(Address) 2125 N. Fulton Ave.

15 SEP 30 1915 ROBERT J. KRAUTER,
 Filed 101. Burial Permit Clerk.
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 29, 1915.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15, 1915, to Sept 29, 1915, that I saw her alive on Sept 29, 1915, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Medullary Carcinoma
 of Cervix Uteri
 Tumor of Ovary
 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infection
 (Duration) yrs. mos. ds.

(Signed) James M. Deane, M. D.
 Sept. 29, 1915 (Address) 710 E. Clark St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem., 10/1/15

20-UNDERTAKER, Chas. J. Evans & Son 118 W. Mt. Royal Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 S. Durham ST.: 2 WARD)2-FULL NAME Frank Kropp(Residence in Baltimore: No. 417 S. Durham St.: 2 yrs., 9 mos., 18 ds.)REGISTERED NO. C 92088533

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male4-COLOR OR RACE White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, 1941

(Month)

(Day)

(Year)

7-AGE, 14

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Janitor(b) General nature of industry, business, or establishment in which employed (or employer). Leather9-BIRTHPLACE, (State or Country), Austria Poland10-NAME OF FATHER, Frank Kropp11-BIRTHPLACE OF FATHER (State or Country), Austria Poland12-MAIDEN NAME OF MOTHER Eva Schneider13-BIRTHPLACE OF MOTHER (State or Country), Austria Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Kropp(Address) 417 S. Durham

15-

FILE

SEP 30 1915

ROBERT KRAUTER,

Bureau Permit Clerk,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 28, 1915

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 28 1915, to Sept 28 1915, that I saw him alive on Sept 28 1915, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Lobar PneumoniaCONTRIBUTORY (Secondary) Cardiac Dilatation(Signed) M. J. Sadovskii, M.D.
Sept 29, 1915. (Address) 2008 15th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. StanislausDATE OF BURIAL, Oct 1st, 191520-UNDERTAKER, M. J. SadovskiiADDRESS 705 S. Ann

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *520 S. Ann*ST. *V* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Stanislawa Kolodziej (Kolodziej)*(Residence in Baltimore: No. *520 S. Ann*St.; yrs. *7* mos. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

July 14, 1915
(Month) (Day) (Year)

7-AGE,

7 yrs. 7 mos. 15 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

John Kolodziej

11-BIRTHPLACE OF FATHER (State or Country),

Austria Poland

12-MAIDEN NAME OF MOTHER

Lucy Czarmicka

13-BIRTHPLACE OF MOTHER (State or Country),

German Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Kolodziej*(Address) *520 S. Ann St*

15-

SEP 30 1915

ROBERT KRAUTER

Filed..... 191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Sept 26, 1915, to Sept 29, 1915*that I saw her alive on *Sept 29, 1915*and that death occurred, on the date stated above, at *1130 P.M.*

The CAUSE OF DEATH* was as follows:

Gastro-enteritis, illa. subita. a malnutrition(Duration)..... yrs. *1* mos. ds.

CONTRIBUTORY (Secondary).....

Broncho-Pneumonia(Duration)..... yrs. mos. *2* ds.(Signed) *Thos. A. Schubert* M. D.*J.B.R.*, 1915. (Address) *422 S. Ann*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Stanislawa

DATE OF BURIAL,

Sept 30, 1915

20-UNDERTAKER

M. F. Sadowski

ADDRESS

705 S. Ann St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Edward A. Dranga
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *209 S. Christo*ST.: *V* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *209 S. Christo*St.; yrs., *7* mos., *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH

Feb, *19*, *1915*
(Month) (Day) (Year)

7-AGE

yrs., *7* mos., *11* ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE, (State or Country),

Baltimore Md.

10-NAME OF FATHER

Frank Dranga

11-BIRTHPLACE OF FATHER (State or Country),

Austria Poland

12-MAIDEN NAME OF MOTHER

Mary Piskor

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Dranga*(Address) *209 S. Christo St.*

15- *SEP 30 1915*
Filed.....

ROBERT KRAUTER
Mortal Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 29, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 20* 1915, to *Sept 29* 1915, that I saw him alive on *Sept 29* 1915, and that death occurred, on the date stated above, at *209* m.

The CAUSE OF DEATH* was as follows:

Sept 29 1915
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.
(Signed).....*H. Dranga* M. D.
Sept 30, 1915. (Address) *16 S. Christo*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

Sept 30, 1915.

20-UNDERTAKER

M. J. Sadowski

ADDRESS

209 S. Christo St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE	
CERTIFICATE OF DEATH	
1-PLACE OF DEATH CITY OF BALTIMORE: (No. <u>531 W Lee</u> ST. <u>22</u> WARD)	
2-FULL NAME <u>Howard Sidney</u>	
(Residence in Baltimore: No. <u>531 W Lee St</u> St. <u>36</u> yrs. <u>—</u> mos. <u>—</u> ds.)	
REGISTERED No. C. <u>—</u>	
(If death occurred in a hospital or institution, give its NAME instead of street and number and add out No. 18.)	
PERSONAL AND STATISTICAL PARTICULARS	
3-SEX <u>Male</u>	4-COLOR OR RACE <u>Colored</u>
5-SINGLE <u>Married</u>	6-DATE OF BIRTH <u>Unknown</u> 18 <u>79</u> (Month) (Day) (Year)
7-AGE <u>36</u> yrs. <u>—</u> mos. <u>—</u> ds. or min.?	8-OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer in</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Factory Gen'l.</u>
9-BIRTHPLACE (State or country) <u>Balto City, Maryland</u>	10-NAME OF FATHER <u>Luther Sidney</u>
11-BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>	12-MAIDEN NAME OF MOTHER <u>Alice Travers</u>
13-BIRTHPLACE OF MOTHER (State or country) <u>Cambridge, Md</u>	14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James Travers</u> (Address) <u>531 W Lee Street</u>
MEDICAL CERTIFICATE OF DEATH	
16-DATE OF DEATH <u>September 28, 1915</u> (Month) (Day) (Year)	
17-I HEREBY CERTIFY, That I attended deceased from <u>Sept 15, 1915</u> to <u>Sept 28, 1915</u> , that I saw him alive on <u>Sept 27, 1915</u> , and that death occurred, on the date stated above, at <u>99</u> m. The CAUSE OF DEATH* was as follows: <u>Typhoid fever</u>	
Contributory (SECONDARY) <u>General debility</u> (Duration) yrs. <u>10</u> mos. <u>—</u> ds.	
(Signed) <u>Bernard S. Grunick</u> M. D. <u>Sept 28, 1915</u> [Address] <u>1707 Edgewood</u>	
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS] At place of death yrs. <u>—</u> mos. <u>—</u> ds. In the State yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? Former or usual residence	
19-PLACE OF BURIAL OR REMOVAL <u>Mt. Auburn</u>	DATE OF BURIAL <u>Oct 1, 1915</u>
20-UNDERTAKER <u>John H. Trudim</u>	ADDRESS <u>192 W. Hill St</u>

15-SEP 30 1915

HARRY O. ARDEEN

Serial Permit Clerk
REGISTRAR

WRITE PERMANENT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88537

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88537

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: — yrs. 3 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWER OR DIVORCED Single

6-DATE OF BIRTH June 22, 1915 (Month) (Day) (Year)

7-AGE — yrs. 3 mos. 7 ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION None (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore Md

10-NAME OF FATHER Henry Bromm

11-BIRTHPLACE OF FATHER (State or country) Baltimore Md

12-MAIDEN NAME OF MOTHER Alice M. Trust

13-BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Mrs Alice M. Bromm (mother) (Informant)

(Address) 1019 Patapsco St

15- SEP 30 1915 HARRY O. ANDREWS Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH September 29, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24, 1915, to Sept 29, 1915, that I saw him alive on Sept 29, 1915, and that death occurred, on the date stated above, at 11 P. m. The CAUSE OF DEATH* was as follows:

Cholera Infantum

Contributory (SECONDARY) Exhaustion

(Signed) Otto W. Kernhardt M. D. Sept 30, 1915 (Address) 1017 S Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Western Cemetery DATE OF BURIAL Oct 1st, 1915

20-UNDERTAKER L. Schloman Son ADDRESS 1039

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2631 Hager St.)2-FULL NAME Frederick J. Rethman ST.: 20 WARD(Residence in Baltimore: No. 2631 Hager)92 C88538
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: _____ yrs., 5 mos., 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH.

Apr 11, 1915
(Month) (Day) (Year)

7-AGE.

25 yrs., 17 mos., 17 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Child

9-BIRTHPLACE, (State or Country).

Balto City

10-NAME OF FATHER.

Frederick J. Rethman

11-BIRTHPLACE OF FATHER (State or Country).

Balto

12-MAIDEN NAME OF MOTHER

Rosie Smith

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosie Rethman(Address) 2631 Hager St.

15-

SEP 30 1915

HARRY O. ANDREWS,

Marial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept, 28, 1915
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Sept 23 1915, to Sept 28 1915, that I saw him alive on Sept 28 1915, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis

CONTRIBUTORY (Secondary)

(Duration) 5 yrs., 5 mos., 5 ds.
Lobar Pneumonia(Signed) Howard W. Jones, M. D.
Sept 30, 1915. (Address) Livingston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 17 yrs., 17 mos., 17 ds. In the State 17 yrs., 17 mos., 17 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Schwarz Cemetery

DATE OF BURIAL.

Oct 2, 1915

20-UNDERTAKER

Willman

ADDRESS

3026 Paul

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

88539

HEALTH DEPARTMENT—CITY OF BALTIMORE

156

88539

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 3003 Belmont avenue, ST. 16 WARD)

FULL NAME Hattie Armstrong,

(Residence in Baltimore: No. 3003 Belmont avenue, St.; yrs. 7 mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married, (Write the word.)

6-DATE OF BIRTH, September 23, 1868. (Month) (Day) (Year)

7-AGE, 47 yrs. 0 mos. 5 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housewife, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), North Carolina,

10-NAME OF FATHER, Samuel H. Griffin,

11-BIRTHPLACE OF FATHER, (State or Country), North Carolina,

12-MAIDEN NAME OF MOTHER, Nannie Trevathan,

13-BIRTHPLACE OF MOTHER, (State or Country), North Carolina,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard D. Armstrong, husband.

(Address) 3003 Belmont avenue.

15- SEP 30 1915 HARRY O. ANDREWS, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 28th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry, and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary congestion due to the inhalation of illuminating gas, ((Suicide))

(Duration) 6 hours ds.

CONTRIBUTORY Melancholia- caused by continued ill health.

(Signed) J. Frederick Hempel, M. D. (Coroner.)

Sept 29, 1915, (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem, DATE OF BURIAL, Oct 1, 1915.

20-UNDERTAKER, John Cook, ADDRESS, 502 E. W. Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88540

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

C88540

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 21 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and Full out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6 DATE OF BIRTH

Apr. 5, 1915

7 AGE

5 yrs. 25 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

Balt. Md.

PARENTS

10 NAME OF FATHER

Frank F. Korman

11 BIRTHPLACE OF FATHER (State or country)

Ger.

12 MAIDEN NAME OF MOTHER

Minnie R. Stein

13 BIRTHPLACE OF MOTHER (State or country)

Balt. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. A. Korman
626 Cross

(Address)

15.

OCT - 1 1915

ROBERT A. RAUTER,

Chief Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 30, 1915

17. I HEREBY CERTIFY, That I attended deceased from

Sept 28, 1915, to, Sept 30, 1915.

that I saw him alive on Sept 29, 1915.

and that death occurred, on the date stated above, at 2:40 A.M.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed),

Dr. E. H. Hoag

M. D.

Oct 1, 1915 (Address) 729 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Mary's, Brooklyn

DATE OF BURIAL

Oct 1, 1915

20. UNDERTAKER

Jas. O. Dignam

ADDRESS

1000 S. Dred

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *8*)

ST. *4*

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME; instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Albion Hotel*)

St.; *18* yrs., *1* mos., *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married* (Write the word.)

6-DATE OF BIRTH. *Aug 1*, *1842* (Month) (Day) (Year)

7-AGE. *72* yrs., *1* mon., *29* ds. It LESS than 1 day, *hrs.* or *min.*

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *None* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Pa*

10-NAME OF FATHER, *William Lester*

11-BIRTHPLACE OF FATHER (State or Country), *md.*

12-MAIDEN NAME OF MOTHER *Ann O'Hara*

13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Clark*

(Address) *Albion Hotel*

15- *ROBERT C. CRUTCHER*

Barclay Dornick Clark

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 30*, *1915* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 24*, *1915*, to *Sept 30*, *1915*, that I saw her alive on *Sept 30*, *1915*, and that death occurred, on the date stated above, at *2:50* p.m.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis

Constriction (Duration) *1* yrs., *1* mos., *1* ds.

CONTRIBUTORY (Secondary) *Coronary Arteriosclerosis*

(Signed) *Edward J. Smith* M. D.

Sept 30, *1915* (Address) *Mary Clark*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs., *5* mos., *5* ds. In the *Albion Hotel* State *Pa*

Where was disease contracted, if not at place of death? *Albion Hotel*

Former or usual residence *Albion Hotel*

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

St Olive Am Washington *Oct 1*, *1915*

20-UNDERTAKER

Henry W Jenkins *Low Co* *Mc Cullen St*

ADDRESS *Orchard*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *931 E. Eager* St.: *10* WARD)2-FULL NAME *Annice V. Brooks*(Residence in Baltimore: No. *931 E. Eager St.* St.: *10* ym. mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *April 18th 1855*7-AGE, *60* yrs. *5* mos. *10* da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *New York*10-NAME OF FATHER, *Thomas Doud*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER *Not Known*13-BIRTHPLACE OF MOTHER (State or Country), *Not Known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Shadrach Brooks*(Address) *931 E. Eager St.*15-*OCT - 1 1915*LIBERT E. RAUTER,
Baptist Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 29, 1915*17-I HEREBY CERTIFY, That I attended deceased from *Sept 28* 1915, to *Sept 29* 1915.that I saw him alive on *Sept 29* 1915, and that death occurred, on the date stated above, at *7:30 p.m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage and Paralysis

CONTRIBUTORY (Secondary)

(Signed) *W. C. Barnes* M. D.
Sept 30, 1915 (Address) *2221 E. Pratt*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *New Cathedral Burying Ground*DATE OF BURIAL, *Oct 2, 1915*20-UNDERTAKER, *Dr. Samuel Jan*ADDRESS, *171 E. Pratt*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Joseph's Hospital, 13

ST. WARD)

2-FULL NAME

Arthur Sprinkle

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

3522 Roland Ave -

St. 2 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Dec 26

1912

(Month)

(Day)

(Year)

7-AGE,

2 8

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore City

PARENTS.

10-NAME OF FATHER,

Raymond Sprinkle

11-BIRTHPLACE OF FATHER
(State or Country),

Ind.

12-MAIDEN NAME OF MOTHER

Emma Mc Melary

13-BIRTHPLACE OF MOTHER
(State or Country),

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. E. Sprinkle

(Address) 3522 Roland Ave.

OCT - 1 1915

ROBERT KRAUTER,

Chief Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept.

(Month)

29

(Day)

1915

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 23 1915, to Sept 27 1915,

that I saw him alive on Sept 29 1915,

and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (acute)

(Duration) yrs. mos. ds. 8

CONTRIBUTORY
(Secondary)

Broncho Pneumonia

(Duration) yrs. mos. ds. 1

(Signed) Kenneth McCallum, M. D.

Sept 29, 1915. (Address) St. Joseph's Hos.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State yrs. mos. ds.

Where was disease contracted, 3522 Roland Ave

if not at place of death?

Former or usual residence 3522 Roland Ave -

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Mary's Hospital

Sept 2, 1915.

20-UNDERTAKER

ADDRESS

Chenoweth & Son Electric Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital*)2-FULL NAME *John E. Ritter*(Residence in Baltimore: No. *University Hospital*)REGISTERED NO. C *74*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *unknown*

(Month)

(Day)

1905

(Year)

7-AGE, *10*

yrs.

mos.

da.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer)*School boy*9-BIRTHPLACE,
(State or Country), *Ind.*10-NAME OF
FATHER, *Walter Ritter*11-BIRTHPLACE
OF FATHER
(State or Country), *Maryland*12-MAIDEN NAME
OF MOTHER *Margaret Callahan*13-BIRTHPLACE
OF MOTHER
(State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Walter Ritter*(Address) *Ellicott City, Md.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 1, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from
July 29 1915, to *August 1* 1915,
that I saw him alive on *August 1* 1915,
and that death occurred, on the date stated above, at *2:30 p. m.*
The CAUSE OF DEATH* was as follows:*Diphtheria Septic Peritonitis*(Duration) *7*

yrs.

mos.

da.

CONTRIBUTORY
(Secondary) *Broncho pneumonia*(Duration) *3*

yrs.

mos.

da.

(Signed) *Harry M. Stear* M. D.
Aug. 1, 1915 (Address) *University Hospital**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
FIENTS, OR RECENT RESIDENTS).At place
of death

yrs.

mos.

da.

In the

yrs.

mos.

da.

Where was disease contracted,
if not at place of death? *Unknown*Former or
usual residence *Ellicott City, Md.*19-PLACE OF BURIAL OR REMOVAL,
*Sylmarville Md*DATE OF BURIAL,
*Aug 2, 1915*20-UNDERTAKER
*Geo. R. Meier*ADDRESS
Sylmarville Md.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT - 1 1915

ROBERT J. CRADOCK,
Chief Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

88545

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91/ 88545

PLACE OF DEATH

CITY OF BALTIMORE (No. 1036 Wilmer alley,

ST. 17 WARD)

FULL NAME Mildred E. Smith,

(Residence in Baltimore: No. 1036 Wilmer alley,

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Female, 4-COLOR OR RACE. Colored, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single, (Write the word.)

6-DATE OF BIRTH, August 5th, 1915. (Month) (Day) (Year)

7-AGE, 0 yrs., 1 mos., 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Virginia,

10-NAME OF FATHER, Bristol Smith,

11-BIRTHPLACE OF FATHER (State or Country), Virginia,

12-MAIDEN NAME OF MOTHER Sophie Waddy,

13-BIRTHPLACE OF MOTHER (State or Country), Virginia,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophie Smith, mother,

(Address) 1036 Wilmer alley.

15- OCT - 1 1915, ROBERT E. RAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 30th, 1915. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, au-

And that said deceased came to her death topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frederick Hempel, M. D. (Coroner.)

Sept. 30, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.:

yrs.

mos.

4 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

PARENTS.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

OCT - 1 1915

ROBERT A. KRAUTER

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 1915, to Oct 1 1915,

that I saw him alive on Sept 1 1915,

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration)..... yrs. mos. ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration)..... yrs. mos. ds.

(Signed)..... M. D.

Oct 1, 1915. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

10/1, 1915

20-UNDERTAKER

ADDRESS

Chas. P. Evans Son 118 Wm. & Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.)

FULL NAME

(Residence in Baltimore: No.)

659 Portland St. 22
Vincent Stropas
659 Portland

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, March 24, 1915 (Month) (Day) (Year)

7-AGE, 6 yrs. 5 mos. 5 da. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, none (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto

10-NAME OF FATHER, Joseph Stropas

11-BIRTHPLACE OF FATHER, (State or Country), Russia

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs John Stropas

(Address) 659 Portland

15- OCT - 1 1915

ROBERT M. RAUTER, Registrar.

Dr. J. J. Oler

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Transition

(Duration) yrs. mos. da.

Signed, J. J. Oler, M. D. (Coroner)

Oct 1, 1915 (Address) 113 Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. da. In the State, yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem.

DATE OF BURIAL, Oct. 1, 1915

20-UNDERTAKER, John Grellianekos

ADDRESS, 520 S. Paca St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88548

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1323 Presbman*)ST. *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Linnel S. James(Residence in Baltimore: No. *1323 Presbman*)St.; yrs., *2* mos., *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

*Colored*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

July 27, 1915
(Month) (Day) (Year)

7-AGE.

yrs. *2* mos. *3* ds.If LESS than 1 day,
....hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).*none*
*Infant*9-BIRTHPLACE,
(State or Country).*Baltimore City*

PARENTS.

10-NAME OF
FATHER.*Harry Edwards*11-BIRTHPLACE
OF FATHER(State or Country), *unknown*12-MAIDEN NAME
OF MOTHER*Jennie James*13-BIRTHPLACE
OF MOTHER(State or Country), *Marlborough Co. S. Carolina*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jennie James*(Address) *1323 Presbman*

15-

OCT - 1 1915

JOSEPH J. BRAUTER,

Filed..... 191..... Serial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 30, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Sept 29 1915, to *Sept 30* 1915,
that I saw him alive on *Sept 30th* 1915,
and that death occurred, on the date stated above, at *3:30 P.m.*

The CAUSE OF DEATH* was as follows:

Uncomplicated
Diarrhoea(Duration).....yrs.mos. *25* ds.CONTRIBUTORY
(Secondary)*typhoid* (Duration).....yrs.mos.ds.(Signed) *W. H. Campbell* M. D.*Sept 30, 1915* (Address) *12369 N. Carey St**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL.

Oct 1, 1915

20-UNDERTAKER

John A. Bright

ADDRESS

117 St. Paul Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88549

91

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Josephine Gurski

2122 Fleet St.

St.; yrs., mos. da.)

MEDICAL CERTIFICATE OF DEATH.

8-SINGLE,
MARRIED, *Sen*
WIDOWED,
OR DIVORCED,
(Write the word.)

Sept. 29th, 1915
(Month) (Day) (Year)

If LESS than 1 day,
....hrs. or....min.

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Baltimore City

Frank Czowski.

try), Russia.

Josephine Czernowska

Russia

(Informant).....Frank Ozowski.
(Address).....2122 7th Flt St.

18-
OCT 1 1975
E. W. Sinclair
Registrar.

Sight. 30, 1915.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased ~~for~~
Sept 30 1915, *Sept 30* 1915,
that I saw her alive on *Sept 30* 1915,
and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

Aspiration Pneumonia

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. da.
(Signed) M. D.
1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place				In the			
of death yrs. mos. ds.	State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

10-PLACE OF BURIAL OR REMOVAL

20-UNDERTAKER

DATE OF BURIAL,
Oct 1 1915

ADDRESS
403 S. Wolfes

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88550

C88550

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No. &

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE,

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15- OCT - 1 1915.

Filed....., 191.....

JOSEPH J. KRAUTER

Bureau Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 1915, to Sept 30 1915, that I saw him alive on Sept 30 1915, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.
Operation.

CONTRIBUTORY (Secondary) Carcinoma of Dilatation

(Signed) C. W. Miller M. D.

Sept 30, 1915. (Address) 1111 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Emory Chapel, Md.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lawn Lake, Md.

Oct 3, 1915.

20-UNDERTAKER

ADDRESS

W. J. McKim & Sons

North Avenue

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
6-DATE OF BIRTH *Sept 28, 1915*
(Month) (Day) (Year)

7-AGE *2* yrs. *2* mos. *2* ds. or *1* day, *1* hrs. If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Ind*

PARENTS 10-NAME OF FATHER *Vincent E. Magee* 11-BIRTHPLACE OF FATHER (State or country) *Ind* 12-MAIDEN NAME OF MOTHER *Eva Wardell* 13-BIRTHPLACE OF MOTHER (State or country) *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Mother* (Address)

15-OCT - 1 1915 *ROBERT KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept 30, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Sept 28, 1915* to *Sept 30, 1915*, that I saw *her* alive on *Sept 29, 1915*, and that death occurred, on the date stated above, at *6.30 a.m.* The CAUSE OF DEATH* was as follows:

Premature Birth
(Duration) yrs. mos. ds.
Contributory (SECONDARY) (Duration) yrs. mos. ds.
(Signed) *Henry Glazman* M. D. *Sept 30, 1915* (Address) *712 W. Fayette St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL COLLEGE OF P. & S. DATE OF BURIAL *SEP 30 1915* ADDRESS

20-Per. Wm. E. WOODALL

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 N Mount ST.; 19 WARD)

2-FULL NAME

(Residence in Baltimore: No. 324 N Mount St.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE

Widower
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown, 1863
(Month) (Day) (Year)

7-AGE,

52

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION,

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Va

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Delphine Green

(Address)

1358 W. 1st St.

15-

OCT. 1 1915

ROBERT J. KRAUTER,

City and County Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

9, 28, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

9-26-15 1915, to 9-28-15 1915,that I saw him alive on 9-28 1915,and that death occurred, on the date stated above, at 6:30 P.m.

The CAUSE OF DEATH* was as follows:

acute enteritis

CONTRIBUTORY... (Secondary)

(Signed) F. L. Carson M. D.9-28-15 (Address) 1524 N. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

National Cemetery

DATE OF BURIAL,

Oct 1, 1915

20-UNDERTAKER

John H. Treadwell

ADDRESS

1420 N. 1st St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. *Robert Garrett Hospital for Children* ST. *21* WARD)

2-FULL NAME

Charles Moore

(If death occurred in a hospital or institution, give its NAME instead of street and number and RN out No. 18.)

(Residence in Baltimore: No.

1128 Ridgely St.

St.; *X* yrs. *13* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

August 20, 1914
(Month) (Day) (Year)

7-AGE

X

yrs.

13

mos.

ds.

or

1 day,

hrs.

mid.

?

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or country)

Baltimore

10-NAME OF FATHER

George Moore

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Annie Haguer

13-BIRTHPLACE OF MOTHER
(State or country)

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mand. Reel

(Address)

1128 Ridgely St.

15-

OCT - 1 1915

JOSEPH KRAUTER,

Chief Clerk

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

September 29, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

September 28, 1915, to September 29, 1915,

that I saw him alive on *September 29, 1915 at 1916 pm*

and that death occurred, on the date stated above, at *10:15 pm*

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary

(Duration)

yrs.

1

mos.

ds.

Contributory
(SECONDARY)

dyspepsia, intestinal

(Duration)

yrs.

1 1/2

mos.

ds.

(Signed)

Walter B. Platts

M. D.

Sept 29, 1915

[Address]

802 Cathedral St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

1 1/2

ds.

In the

yrs.

mos.

Where was disease contracted,

If not at place of death?

at home

Former or usual residence

1045 Ridgely St.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Int. Cemetery Oct 2nd, 1915

20-UNDERTAKER

ADDRESS

F. A. Krause 703 Hanover

Eunice M. Russell. HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 N North ave 14

REGISTERED No. C.

2-FULL NAME

(Residence in Baltimore: No. 1323 N North ave St. W yrs. 1 mos. 3 da.)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Single
(Write the word.)

6-DATE OF BIRTH

Aug 27, 1893
(Month) (Day) (Year)

7-AGE

22 yrs. 1 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie R. Russell

(Address) 1323 N North ave

15-

OCT - 1 1915

127 E. North ave

ROBERT

KRAUTH

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 30, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan 24 1915, to Sept 30 1915, that I saw her alive on Sept 24 1915, and that death occurred, on the date stated above, at 530 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

CONTRIBUTORY (Secondary)

Obstruction of Lungs

(Signed) J. H. Kling M. D.

Sept 14 1915 (Address) 127 E. North ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Underground

UNDERTAKER

W. H. Russell

20-DATE OF BURIAL.

Oct 1, 1915

ADDRESS

North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Gladys Robinson*(Residence in Baltimore: No. *Johns Hopkins Hospital* St. yrs. mos. *9* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Caucas

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 29, 1915
(Month) (Day) (Year)

7-AGE,

yrs. *2 1/2* mos. da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),*md.*

10-NAME OF FATHER,

*Jesse Robinson*11-BIRTHPLACE OF FATHER
(State or Country),*Va*

12-MAIDEN NAME OF MOTHER

*Margaret White*13-BIRTHPLACE OF MOTHER
(State or Country),*Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. J. Smith*(Address) *Johns Hopkins Hospital*

15-

OCT - 1 1915

Filed

191

ROBERT KRAUTER
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 30, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept. 21* 1915, to *Sept 30* 1915, that I saw her alive on *September 30* 1915, and that death occurred, on the date stated above, at *11:25* pm.

The CAUSE OF DEATH* was as follows:

Indigestion & Intestinal(Duration) yrs. *1* mos. da.CONTRIBUTORY
(Secondary)*Bronchopneumonia, Pyelonephritis*(Duration) yrs. *14* mos. da.(Signed) *G. F. Power*

M. D.

Oct 6, 1915 (Address) *Johns Hopkins Hosp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *9* mos. da. In the State yrs. *✓* mos. *✓* da.

Where was disease contracted, if not at place of death?

Former or usual residence *809 J. St Sparrows Point*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Sparrows Pt md**Oct 2*, 1915

20-UNDERTAKER

ADDRESS

Christy Dingle *705 Light*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Vincent's Infirmary* ST. *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St Vincent's Infirmary* St.: yrs. *1* mos. *28* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

August 1st, 1915
(Month) (Day) (Year)

7-AGE.

yrs. *1* mos. *28* ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*None*9-BIRTHPLACE,
(State or Country),*Maryland*
Unknown

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St Vincent's*(Address) *1401 Division St*

15-

OCT - 2 1915

EUGENE KRAUTER,

191 *Carlat. Permit Clerk.*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 28, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 1st* 1915, to *Sept 28* 1915, that I saw him alive on *Sept 28* 1915, and that death occurred, on the date stated above, at *10:47* m. The CAUSE OF DEATH* was as follows:*M. tuberculosis and*
M. al. assimilation(Duration) yrs. *1* mos. *28* ds.CONTRIBUTORY
(Secondary)(Duration) yrs. *1* mos. *28* ds.(Signed) *John S. L. L. L. M. D.**Sept. 28, 1915* (Address) *1223 N. Caroline St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *1* mos. *28* ds. In the State yrs. *1* mos. *28* ds.Where was disease contracted, if not at place of death? *St Vincent's Infirmary*Former or usual residence *St Vincent's Infirmary*

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Cathedral *Oct 2, 1915*

20-UNDERTAKER ADDRESS

H. Faher & Sons 606 Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital

ST.;

WARD)

REGISTERED NO. C

2-FULL NAME

Edward Oberdelhoff

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

2002 McElderry St

St.;

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

February

22

1868

(Month)

(Day)

(Year)

7-AGE,

47

yrs.

7

mos.

8

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Photographer

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Md. Balto

10-NAME OF FATHER,

Wm Oberdelhoff

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Frederica Frank

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

A J Smith

(Address).....

Johns Hopkins Hospital

15-

OCT - 2 1915

HARRY O. ANDREWS,

Filed.....

191

Surgeon-General

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September

30

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 29

1915

to

Sept 30

1915

that I saw him alive on

September 30

1915

and that death occurred, on the date stated above, at

7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Chronic hepatitis, Arteriosclerosis

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

Oct 1, 1915. (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITAL, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

2002 McElderry St

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Schwartz Cem

Oct 3 1915

20-UNDERTAKER

Wm Cook

ADDRESS

1026 W. ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *921 S. Decker* ST.; *1* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *921 S. Decker Ave* St.; *2* yrs., *2* mos., *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widowed

6-DATE OF BIRTH.

January 24, 1828

(Month)

(Day)

(Year)

7-AGE.

87 yrs., *8* mos., *6* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE,

(State or Country).

Germany

10-NAME OF FATHER.

John Rystubus

11-BIRTHPLACE OF FATHER

(State or Country)

Germany

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country).

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Laura Moore

(Address)

921 S. Decker Ave

15-

OCT. - 2, 1915

HARRY O. ANDREWS,

Bartol Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 30, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Sept 25, 1915, to Sept 30, 1915*that I saw her alive on *Sept 29, 1915*and that death occurred, on the date stated above, at *8:20 a.m.*

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY

(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *H. B. Titlow* M. D.*Sept 30, 1915* (Address) *3035 Cornwall St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Valley Redeemer Chh

DATE OF BURIAL

Oct 2, 1915

20-UNDERTAKER

Will Cook

ADDRESS

5076 No. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88559

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88559

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *1717 Barclay*)

ST. *12* WARD)

FULL NAME

Elizabeth Elvira Cole

(Residence in Baltimore: No. *1717 Barclay*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female.

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Child*

6-DATE OF BIRTH,

July 10, 1914
(Month) (Day) (Year)

7-AGE,

14 yrs. *20* mos. *20* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9-BIRTHPLACE, (State or Country),

City

10-NAME OF FATHER,

Joseph Cole

11-BIRTHPLACE OF FATHER (State or Country),

Washington D. C.

12-MAIDEN NAME OF MOTHER

Margaret Martin

13-BIRTHPLACE OF MOTHER (State or Country),

City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

Mrs. Margaret Cole
1717 Barclay St.

15-

OCT - 2 1915

HARRY O. ANDREWS,

101... *Serial Permit 4101* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

September 30, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsion

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Transition

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

Oct 1, 1915 (Address) *18 W. Franklin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?...

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Washington DC

DATE OF BURIAL,

Oct 2, 1915

20-UNDERTAKER

William Cook

ADDRESS

302 E North

C88560

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88560

CERTIFICATE OF DEATH.

137
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *304 Fremont Ave* ST. *21* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *304 Fremont Ave* St.; *19* yrs., *10* mos., *24* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, *married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Nov 6, 1895
(Month) (Day) (Year)

7-AGE,

*19 yrs., 10 mos., 24 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),*Baltimore Md*

10-NAME OF FATHER,

*August Warner*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Mary Robinson*13-BIRTHPLACE OF MOTHER
(State or Country),*South Carolina*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Christian Litter*(Address) *304 Fremont Ave*15-
OCT - 2 1915
Filed

HARRY O. ANDREWS,

191... *Bureau of Health*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 30, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 1* 1915, to *Sept 29* 1915, that I saw her alive on *Sept 28* 1915, and that death occurred, on the date stated above, at *99* m.

The CAUSE OF DEATH* was as follows:

Septicemia
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)(Signed) *Walter A. Cox* M. D.
9-30, 1915 (Address) *Sanitarium, Elmhurst*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Frederick Law's Cem DATE OF BURIAL, *Oct 3, 1915*

20-UNDERTAKER

Cost B. Cook ADDRESS *1003 W Balto*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1269 Riverside* ST.: *24* WARD)REGISTERED NO. C *79*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Patrick R. Lee*(Residence in Baltimore: No. *1269 Riverside* av St.: *30* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married*
(Write the word.)6-DATE OF BIRTH, *June 17, 1885*

(Month)

(Day)

(Year)

7-AGE, *60* yrs. *3* mos. *12* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Guard watchman*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Ireland*10-NAME OF FATHER, *Reuben Lee*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER, *Catharin Ryan*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Mr Reuben Lee (Son)*(Address), *1269 Riverside*

15-

Filed

OCT - 2 1915

HARRY O. ANDREWS,

Berial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sep 29, 1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sep 27, 1915*, to *Sep 29, 1915*, that I saw him alive on *Sep 29, 1915*, and that death occurred, on the date stated above, at *10 P* m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis(Duration) ... yrs. *6* mos. *12* ds.CONTRIBUTORY (Secondary) *Nephritis + autumal*(Duration) ... yrs. *6* mos. *12* ds.(Signed) *J. J. Lurking* M. D.*9.1.30, 1915* (Address) *102 E. Fort Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Catharin Lee*, *Oct 2, 1915*20-UNDERTAKER ADDRESS *318 E. 1st St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88563

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1951 N. Patterson Pk. Ave. ST.; 64 WARD)

2-FULL NAME

Martin Calvin Garner(Residence in Baltimore: No. 1951 N. Patterson Pk. Ave. St.; 64 yrs., 1 mos., 18 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH

Mar 20

(Month)

(Day)

18 30 (Year)

7-AGE

6 yrs., 6 mos., 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Carpenter(b) General nature of industry, business, or establishment in which employed (or employer) House9-BIRTHPLACE, (State or Country), Leamace C. and10-NAME OF FATHER, Sam H. Garner11-BIRTHPLACE OF FATHER, (State or Country), Leamace C. and12-MAIDEN NAME OF MOTHER Lillian C. Garner13-BIRTHPLACE OF MOTHER, (State or Country), Leamace C. and

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin C. Garner(Address) 1951 N. Patterson Pk. Ave.

15-

OCT - 2 1915

Filed

191

HARRY O. ANDREWS,
Serial Permit No. 0101
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 30, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1915, to Sept 30 1915, that I saw him alive on Sept 30 1915, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. mos. ds.

(Signed) John T. Owens M. D.191... (Address) 1413 N. 23rd Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Steele & Mar. and

DATE OF BURIAL

Oct 2, 1915

20-UNDERTAKER

Robert J. Turner

ADDRESS

1413 N. 23rd Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. 2448 Maryland Ave. ST.; 12 WARD)

2-FULL NAME

Ella E. Izard(Residence in Baltimore: No. 2448 Maryland Ave. St.; 30 yrs., 00 mos. 00 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
(Write the word)

6-DATE OF BIRTH,

April 10, 1840
(Month) (Day) (Year)

7-AGE,

75 yrs. 5 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Lady.9-BIRTHPLACE,
(State or Country),Charleston S.C.

10-NAME OF FATHER,

Ralph Izard.11-BIRTHPLACE OF FATHER
(State or Country),South Carolina

12-MAIDEN NAME OF MOTHER

Rosa E. Pinckney13-BIRTHPLACE OF MOTHER
(State or Country),S.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Dr. Cowie May(Address) Philadelphia Pa.OCT - 2 1915HARRY C. ANDREWS,Filed..... 191... Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

1911, to Sept 29, 1915that I saw her alive on Sept 29, 1915and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Heart disease
(Mitral insufficiency with
dilatation)(Duration) 4 yrs. 00 mos. 00 ds.CONTRIBUTORY
(Secondary)Coronary Dilatation(Duration) 7 yrs. 00 mos. 00 ds.(Signed) R. Duval Altman, M. D.Oct 1, 1915. (Address) 931 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Newport R. I.

DATE OF BURIAL,

10-3, 1915

20-UNDERTAKER

Henry W. Jenkins Sons Co

ADDRESS

McLulloch & Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88566

CERTIFICATE OF DEATH

120
20
REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2517 N Fayette

2 FULL NAME John Hirsch.

(Residence in Baltimore: No. 2517 N Fayette

ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 75 yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

6 DATE OF BIRTH Nov 25, 1839 (Month) (Day) (Year)

7 AGE 75 yrs. 11 mos. 5 ds. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Former of Western (b) General nature of industry, business, or establishment in which employed (or employer) Cemetery

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER George Hirsch

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Mohler

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Anne M. Hirsch

(Address) 2517 N. Fayette St

15 OCT - 2 1915

HARRY O. ANDREWS,

Serial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 30, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Aug 26, 1915, to Sept 30, 1915, that I saw him alive on Sept 29, 1915, and that death occurred, on the date stated above, at 8 a m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis -

(Duration) yrs. 1 mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Edward O. Condon M. D. Sept 30, 1915 (Address) 750 N. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Western Cemetery DATE OF BURIAL Oct 3, 1915

20 UNDERTAKER George J. Smith 2517 N. Fayette St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88567

C88567

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Serial

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

that saw her alive on

and that death occurred, on the date stated above, at 12:20 p.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) Edgar P. Froedenwald, M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 15 ds. In the State yrs. 2 mos. 23 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificate.

C88568

HEALTH DEPARTMENT-CITY OF BALTIMORE

C88568

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1201 Madison Ave.

REGISTERED NO. C

ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore M. Keeney

(Residence in Baltimore: No. 1201 Madison Ave.

abt 1 year.
St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

6-DATE OF BIRTH April 12, 1832
(Month) (Day) (Year)

7-AGE 83 yrs. 5 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION Retired Builder
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE Pa.
(State or country)

10-NAME OF FATHER John Keeney.

11-BIRTHPLACE OF FATHER Pa.
(State or country)

12-MAIDEN NAME OF MOTHER Delia Hagner

13-BIRTHPLACE OF MOTHER Pa.
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. C. Clarke

(Address) 1201 Madison Ave.

15. OCT - 2 1915 ROBERT J. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 10 1, 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1914, to Oct 1, 1915, that I saw him alive on Oct 1, 1915, and that death occurred, on the date stated above, at 1 P. m. The CAUSE OF DEATH* was as follows:

Chronic Interstital Ne, tritis

(Duration) 4 yrs. mos. ds.

Contributory (SECONDARY)

(Signed) James C. Clark M. D.
Oct 1, 1915 (Address) 1201 Madison Ave

*State the DISEASE CAUSING DEATH, or, in short, a brief, violent CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Phila. Pa.

DATE OF BURIAL Oct. 2, 1915

20-UNDERTAKER McLean & Jones

ADDRESS 833 Linden Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88570

CERTIFICATE OF DEATH.

152 C88570
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 10386 Vine ST.; 18 WARD)

2-FULL NAME

Residence in Baltimore: No. 10386 Vine

St.: 0 yrs., 0 mos. 0 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) Single

6-DATE OF BIRTH.

Sept 29, 1915

7-AGE.

6 yrs. 0 mos. 0 ds. If LESS than 1 day, 22 hrs. or 4 min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Joseph Corbin

(Address) 10386 Vine

15-

OCT - 2 1915

ROBERT KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 30, 1915

17- I HEREBY CERTIFY, That I attended deceased from

9-29 1915, to 9-30 1915,

that I saw him alive on 9-29 1915,

and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(Duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) P. D. Rush M. D.

4-30, 1915 (Address) 1000 Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Mount Auburn Cem

DATE OF BURIAL.

Oct 2 1915

20-UNDERTAKER

John J. Leaw & Co

ADDRESS

901 Volusia St

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88571

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1434 Anthony* ST.; *10* WARD)

2-FULL NAME

Jacob Rackensperger(Residence in Baltimore: No. *1434 Anthony* St.; *67* yrs., *—* mos., *—* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widower

6-DATE OF BIRTH,

Not known

(Month)

(Day)

(Year)

7-AGE,

70

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Harnesse Maker

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER

(State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Magdalena Herrmann

(Address)

1434 Anthony St.

15-

FILED

OCT. - 2 1915

EDMUND J. GRAUTER,

Chief Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 30, 1915

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *Sept 29 1915*, to *Sept 30 1915*, that I saw him live on *Sept 30 1915*, and that death occurred, on the date stated above, at *9⁰⁰ P.m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

William F. Jones

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cemetery

DATE OF BURIAL,

Oct. 4, 1915

20-UNDERTAKER

Henry Stork

ADDRESS

1301 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1700 Crystle Ave* ST. *8* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1700 Crystle Ave* St. *8* yrs. *1* mos. *7* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out Nos. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Aug 27, 1915
(Month) (Day) (Year)

7-AGE,

1 mos. 9 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

City Balto

10-NAME OF FATHER,

Ulfrid P. Itner

11-BIRTHPLACE OF FATHER

(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Annie Wunderlich

13-BIRTHPLACE OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. P. Itner*(Address) *1700 Crystle Ave*

15-

Filed

*OCT - 2 1915**BERT . KRAUTER,**Dir. of Health Dept.*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Sept 16, 1915, to Oct 1, 1915,*that I saw him alive on *Oct 1, 1915,*and that death occurred, on the date stated above, at *120* a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis(Duration) *15 ds.*CONTRIBUTORY
(Secondary)(Duration) *15 ds.*(Signed) *Harold Fisher, M. D.**Oct 1, 1915. (Address) 1926 E. 6th St. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *15 ds.* In the State *15 ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*McBarnes**Oct 2, 1915*

20-UNDERTAKER

Philip Herwig

ADDRESS

2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

28 088573
REGISTERED NO. C.

CITY OF BALTIMORE: (No. 727 Cumberland ST. 21 WARD)

2-FULL NAME

Catherine E. Bucheimer

(Residence in Baltimore: No.

1143 Ridgely

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and Report No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

July 12, 1874

7-AGE

41 yrs. 2 mos. 17 ds. or min.?

If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE
(State or country)

Balto. Md.

PARENTS

10-NAME OF FATHER

Don't know

11-BIRTHPLACE OF FATHER
(State or country)

Don't know

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER
(State or country)

Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Bucheimer

(Address)

1143 Ridgely

15-

OCT - 2 1915

Filed

191

ROBERT V. KRAUTER

Chief Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Sept 29, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 24, 1915, to, Sept 29, 1915,

that I saw her alive on Sept 29, 1915,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about 7

(Duration)

yrs.

mos.

ds.

Contributory
(SECONDARY)

(Signed)

A. E. Kniff

Oct 1

1915

[Address]

1002 McLean

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,
if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Wesleyan Church

DATE OF BURIAL

Oct 13, 1915

20-UNDERTAKER

Samuel E. Egan

ADDRESS

1002 McLean

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

10-LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-OCT - 2 1915

Filed..... 191

16-REGENT . KRAUTER

17-Marial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride of Mercury poisoning.
Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

(Duration) yrs. mos. ds.

(Signed) M. D. M. D. M. D.

(Coroner.)

Oct 1, 1915 (Address) 1729 Maplewood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

518 N. Lakewood Ave

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

1842 1/2 Boring

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *218 Sbarney* ST.: *19* WARD)2-FULL NAME *Mary M. Steen*(Residence in Baltimore: No. *218 Sbarney* St.: yrs. *6* mos. *6* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 1st

(Month)

(Day)

1915
(Year)

7-AGE,

6 yrs. *6* mos. *6* ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), *Balt Md*10-NAME OF FATHER, *Michael Steen*

11-BIRTHPLACE OF FATHER

(State or Country), *Balt Md*12-MAIDEN NAME OF MOTHER *Ethel Spearman*

13-BIRTHPLACE OF MOTHER

(State or Country), *Balt Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Michael Steen*(Address) *218 Sbarney St*

15-

OCT. 2, 1915

JOSEPH E. KRAUTER

Baltimore Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 1

(Month)

(Day)

1915
(Year)

I HEREBY CERTIFY, That I attended deceased from

Sept 23 191*5* to *Oct 1* 191*5*that I saw her alive on *Sept 30* 191*5*,and that death occurred, on the date stated above, at *8:45* a.m.

The CAUSE OF DEATH* was as follows:

Asphyxia 10 days

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) *Malaria*

(Duration).....yrs.....mos.....ds.

(Signed) *J. H. Smith* M. D.*Oct 1*, 191*5* (Address) *7 N. Cherry*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

St. Peter's Cemetery

DATE OF BURIAL,

Oct 2, 1915

20-UNDERTAKER

John J. Fields 1200 N. Lombard St

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE.

CERTIFICATE OF DEATH

C88576

C88576

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *213 N. Poppleton St.* ST. *18* WARD)

2-FULL NAME *Elmer Harrington Laughlin*

(Residence in Baltimore: No. *213 N. Poppleton St.* St. yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and Unit No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

6-DATE OF BIRTH *September 15, 1915* (Month) (Day) (Year)

7-AGE *15* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work *Child*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Baltimore City

10-NAME OF FATHER

Harry Laughlin

11-BIRTHPLACE OF FATHER (State or country)

Washington D.C.

12-MAIDEN NAME OF MOTHER

Margaret Tuttle

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore-Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Margaret Laughlin

(Address)

213 N. Poppleton St.

15-

Filed

OCT - 2 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

October 10, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 15, 1915, to *Oct 12, 1915*

that I saw him alive on *Oct 12, 1915*

and that death occurred, on the date stated above, at *8:30 P.m.*

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *Robt J. Murray M.D.* *Oct 2, 1915* (Address) *510 N. Fremont An*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Petera

DATE OF BURIAL

Oct 2, 1915

20-UNDERTAKER

Henry Brummage Son

ADDRESS

511 N. Schroeder St

Jina Bochniak
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *620 S. Bond*ST. *3* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. *620 S. Bond*St. yrs. *5* mos. *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

*April**13**1915*

(Month)

(Day)

(Year)

7-AGE.

*5**18*

ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country).*Baltimore Md.*

10-NAME OF FATHER.

*Jacob Bochniak*11-BIRTHPLACE OF FATHER
(State or Country).*Austria Poland.*

12-MAIDEN NAME OF MOTHER

*Coraline Rok*13-BIRTHPLACE OF MOTHER
(State or Country).*Austria Poland.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Coraline Bochniak*(Address) *620 S. Bond St.*

15-

FILED

*OCT - 2 1915**ROBERT J. KRAUTER**Chief Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*Oct**2**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Sept 3**1915*

to

*Oct 2**1915*

that I saw him alive on

*Oct 2**1915*and that death occurred, on the date stated above, at *6 P* m.

The CAUSE OF DEATH* was as follows:

*Acute Spinal Meningitis**acute spinal*

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....

*Oct 2**1915*(Address) *16 S Bond*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL.

Oct. 3, 1915

20-UNDERTAKER

M. F. Sadowski

ADDRESS

705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. **AGE** should be stated **EXACTLY**. **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms, so that it may be properly classified. **Exact statement of OCCUPATION** is very important. See instructions on back of certificate.

4-9-1950 134702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2811 Woodbrook Ave. 13

WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2811 Woodbrook Ave. St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH.

March 23, 1911

(Month)

(Day)

(Year)

7-AGE.

4 yrs. 6 mos. 8 da.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.

(State or Country),

Baltimore City

PARENTS.

10-NAME OF FATHER.

Dane L. Alder.

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore Co.

12-MAIDEN NAME OF MOTHER

Maudie A. Mordeau

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Maudie Alder

(Address)

2811 Woodbrook Ave.

15-

ROBERT KRAUTER

. KRÄUTER

Baltimore Permit Clerk

Registrar.

Filed

OCT - 2 1915

191

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

October 2nd, 1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 19th 1915, to Oct 2nd 1915, that I saw her alive on Oct. 2nd 1915, and that death occurred, on the date stated above, at 12:45 m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Malignant)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

Diphtheria

(Signed)

(Duration) yrs. mos. da.

Oct. 2, 1915 (Address) 1605 N. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Loudon Park

DATE OF BURIAL.

Oct 3, 1915

20-UNDERTAKER

H. J. K. Smith

ADDRESS

Pomeroy North

2 P. M.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1608 Lorman street, ST. 15 WARD)

2-FULL NAME John Young,

(Residence in Baltimore: No. 1608 Lorman street,

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male,

4-COLOR OR RACE,

Colored,

5-SINGLE,

Single,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

August 4th, 1915.
(Month) (Day) (Year)

7-AGE,

0 yrs. 1 mos. 27 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Tabe Young,

11-BIRTHPLACE OF FATHER

(State or Country),

Virginia,

12-MAIDEN NAME OF MOTHER

Priscilla Toblin,

13-BIRTHPLACE OF MOTHER

(State or Country),

Virginia,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stevens Spencer, friend,

(Address) 1608 Lorman street.

15-

OCT - 2 1915

ROBERT KRAUTER

Filed 1915

Notary Public

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

October 1st, 1915.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry and that said deceased came to his death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Campbell M. D.
(Coroner.)

Oct. 2, 1915 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *2601 N. Fairmount* ST *20* WARD)

2-FULL NAME *George V. Hatz*

(If death occurred in a hospital or institution, give its NAME instead of street and number and RH out No. 12.)

(Residence in Baltimore: No. *2601 N. Fairmount*

St.; *54* yrs. *11* mos. *28* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *Oct 2, 1860*
(Month) (Day) (Year)

7-AGE *54* yrs. *4* mos. *28* ds. or *1* day *15* hrs. *15* min.?
If LESS than 1 day, hrs. min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work *Wholesale*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Baltimore Md*

PARENTS
10-NAME OF FATHER *Andrew Hatz*
11-BIRTHPLACE OF FATHER (State or country) *Germany*
12-MAIDEN NAME OF MOTHER *Unknown*
13-BIRTHPLACE OF MOTHER (State or country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs G. Hatz*

(Address) *2601 N. Fairmount*

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept 3, 1915*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *Sept 25, 1915*, to, *Sept 30, 1915*, that I saw him alive on *Sept 30, 1915*, and that death occurred, on the date stated above, at *15* m. The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(Duration) yrs. mos. *5* ds.

Contributory (SECONDARY)

(Signed) *Harry Boyd* M. D. *Oct 1, 1915* [Address] *62 Columbia*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Balto Cemetery*

DATE OF BURIAL *Oct 3, 1915*

20-UNDERTAKER *J. W. M. Cully*

ADDRESS *37 E. Post Ave*

15- *OCT - 2, 1915* *JOSEPH C. KRAUTER* REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.; *1* WARD)2-FULL NAME *Rosa Wolf*(Residence in Baltimore: No. *2124 Eastern Ave* St.; *Life* yrs., *Life* mos., *Life* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED, *Single*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

*February**21*

(Month)

(Day)

1915
(Year)

7-AGE,

*7**7**ds.*

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),*md 13 alts*

10-NAME OF FATHER,

Wm. H. Wolf

11-BIRTHPLACE OF FATHER

(State or Country), *md.*

12-MAIDEN NAME OF MOTHER

Margaret Stewart

13-BIRTHPLACE OF MOTHER

(State or Country), *md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. J. Smith*(Address) *Johns Hopkins Hospital*

15-

Filed

OCT - 2 1915

1915

ROBERT

KRAUTER,

Baltimore, Md.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*October**1**1915*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Sept. 27**1915*, to *October 1**1915*that I saw him alive on *October* *1915*,and that death occurred, on the date stated above, at *9 a.m.*

The CAUSE OF DEATH* was as follows:

Alimentary Intoxication

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *A. J. Smith* M. D.*Oct. 1, 1915* (Address) *Johns Hopkins Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence *2124 Eastern Ave*

19-PLACE OF BURIAL OR REMOVAL,

BALTIMORE CEMETARY

DATE OF BURIAL

OCT 3 - 1915

20-UNDERTAKER

ARMSTRONG DENNY CO.

ADDRESS

715 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *931 Charles* ST.; *23* WARD)

2-FULL NAME *Muriel S. Smith*

(Residence in Baltimore: No. *931 Charles* St.; *Life* yrs. *mon.* *ds.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*

4-COLOR OR RACE, *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)

6-DATE OF BIRTH, *May 15, 1912*

7-AGE, *3 yrs. 4 mos. 15 ds.*

If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore Md*

10-NAME OF FATHER, *John W. Smith*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER, *Victoria Sanford*

13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John W. Smith*

(Address) *931 S Charles St*

15-OCT - 2 1915

Filed. 191.

J. B. KRAUTER

Chief Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *October 15, 1915*

17- I HEREBY CERTIFY, That I attended deceased from *May 18* 1915, to *Oct 15* 1915, that I saw her alive on *Oct 15* 1915, and that death occurred, on the date stated above, at *10* a.m.

The CAUSE OF DEATH* was as follows:

General Tuberculosis
(Duration) *5* yrs. *mon.* *ds.*

CONTRIBUTORY (Secondary)

(Duration) *5* yrs. *mon.* *ds.*
(Signed) *J. B. Krauter* M. D.
Oct 17, 1915 (Address) *107 S Wm St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cedar Hill*

DATE OF BURIAL, *OCT 3, 1915*

20-UNDERTAKER, *ARMSTRONG-DENNY CO.*

ADDRESS *715 Light St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asy.* ST.; *14* WARD)

REGISTERED NO. C

2-FULL NAME

Henry Price

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *St. Vincent's Inf. Asylum* St.; *2* yrs., *2* mos., *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

July 28, 1915
(Month) (Day) (Year)

7-AGE,

2 yrs., *2* mos., *2* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's*(Address) *1401 Division St.*

15-

OCT - 2 1915

Filed

C. R. RAUTER,

M. J. VERNITZ,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 30, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept 1st* 1915, to *Sept 30* 1915, that I saw him alive on *Sept 30* 1915, and that death occurred, on the date stated above, at *6:00* p. m.

The CAUSE OF DEATH* was as follows:

Malnutrition and Malassimilation
(Duration) *2* yrs., *2* mos., *2* ds.CONTRIBUTORY
(Secondary)(Signed) *John S. Fendley, M. D.*
Oct 1st, 1915 (Address) *1223 N. Calver St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs., *2* mos., *2* ds. In the State *2* yrs., *2* mos., *2* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *St. Vincent's Inf. Asylum*

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Room

DATE OF BURIAL,

Oct 3, 1915

20-UNDERTAKER

Marion F. Heyday
ADDRESS *1617 Fayette Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *Hebrew Hosp.*)

ST. *7* WARD)

2-FULL NAME *Rayfield Levinson*

(Residence in Baltimore: No. *Hebrew Hosp.*)

St. *7* yrs. *2* mos. *2* ds.)

(If death occurred in a hospital or institution, give its NAME. Instead of street and number and fill out No. 14.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

6-DATE OF BIRTH *November*, 1912 (Month) (Day) (Year)

7-AGE *Two* yrs. *Ten* mos. *ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *none* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Ellicott City Md*

10-NAME OF FATHER *Abraham Levinson*

11-BIRTHPLACE OF FATHER (State or country) *Russia*

12-MAIDEN NAME OF MOTHER *Anna*

13-BIRTHPLACE OF MOTHER (State or country) *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Abraham Levinson*

(Address) *Hebrew Hospital*

15- *OCT - 3 1915* *ROBERT F. RAUTER* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Oct. 2nd*, 1915 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 10th*, 1915, to *Oct 2nd*, 1915, that I saw him alive on *Oct 1st*, 1915, and that death occurred, on the date stated above, at *12:10 AM*. The CAUSE OF DEATH* was as follows:

Acute osteomyelitis of the left femur (Duration) yrs. mos. *26* ds.

Contributory *Staphylococcus* (SECONDARY) *Sepsis* (Duration) yrs. mos. *31* ds. (Signed) *M. B. Levy* M. D. (Address) *Hebrew Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. *22* ds. In the State yrs. mos. *2* ds.

Where was disease contracted? *Ellicott City*

If not at place of death? *Ellicott City*

Former or usual residence *Ellicott City*

19-PLACE OF BURIAL OR REMOVAL *Hebrew Hospital* 20-UNDERTAKER *S. Levinson + But Balt.*

ADDRESS *1107 E*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2500 Francis* ST.; *13* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Early K Johnson*(Residence in Baltimore: No. *2500 Francis Street* St.; yrs. mos. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Sept 16, 1915
(Month) (Day) (Year)

7-AGE,

15 yrs. *15* mos. *15* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Child

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Early H. Johnson

11-BIRTHPLACE OF FATHER

(State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Sue Henderson

13-BIRTHPLACE OF MOTHER

(State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Early H. Johnson*(Address) *2500 Francis St.*

15-

Filed

*OCT - 3, 1915**Robert J. Krauth*
Bertal Vermit Oler

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 1, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 16, 1915, to *Oct 1, 1915*,that I saw him alive on *Oct 1, 1915*,and that death occurred, on the date stated above, at *68* m.

The CAUSE OF DEATH* was as follows:

Heart failure instrumental
slavery(Duration) yrs. mos. *14* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. *14* ds.(Signed) *J. A. Melvin* M. D.*Oct 1, 1915* (Address) *1303 W. North*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Doris Wharf *Oct 3, 1915*

20-UNDERTAKER

ADDRESS

William Cook *501 E. North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1519 Preston* ST.; *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1519 Preston* St.; yrs., mos. *2*, ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*col.*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 24th, 1887
(Month) (Day) (Year)

7-AGE,

28 yrs. *2* mos. *7* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laundress
Private Family

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Jones

11-BIRTHPLACE OF FATHER

(State or Country),

Oriskany

12-MAIDEN NAME OF MOTHER

Lottie Kellum

13-BIRTHPLACE OF MOTHER

(State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss St. Blackstone*(Address) *1519 Preston St.*

15-

Filed *OCT - 3 - 1915*

ROBERT F. FRAUTER, Registrar.

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct., *1st*, 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept. 18*, 1915, to *Oct. 1*, 1915, that I saw him alive on *Oct. 1*, 1915, and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH* was as follows:

Acute Mitral Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Chronic Bronchitis
Nephritis (Duration) yrs. mos. ds.(Signed) *Paul Brown* M. D.*Oct. 1*, 1915 (Address) *1837 Pine Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Auburn

DATE OF BURIAL,

Oct. 3, 1915

20-UNDERTAKER

John H. Owens

ADDRESS

1222 Anna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88589

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

Hebrew Hosp. 3

Jennie Baer

48 Albermarle St

ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH Oct. 1, 1845 (Month) (Day) (Year)

7-AGE 70 yrs. - mos. - ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE (State or country) Russia

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Lewis

1419 E. Balt St

15.

OCT - 3 1915

ROBERT J. KRAUTER,

Deputy Health Officer,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Oct. 1, 1915 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/15, 1915, to Oct. 1, 1915, that I saw her alive on Oct. 1, 1915, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Colon (no operation, autopsy not section obtained)

Contributory (SECONDARY) Acute Catarrhal Enterocolitis (Duration) 1 yrs. 6 mos. ds.

(Signed) M. B. Revi M. D. 10/1, 1915 (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death - yrs. - mos. 16 ds. In the State 10 yrs. mos. ds. Where was disease contracted, 48 Albermarle St If not at place of death? Former or usual residence 48 Albermarle St

19-PLACE OF BURIAL OR REMOVAL Hebrew Herrin Run DATE OF BURIAL Oct 3, 1915

20-UNDERTAKER Jack Lewis 1419 E. Balt St ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *1804 E. Baltimore* ST. *2* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 11.)

2-FULL NAME

Anna Lindler (Lindler)(Residence in Baltimore: No. *1804 E. Baltimore* St.; *25* yrs., *7* mos. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

March *7*, *1890*
(Month) (Day) (Year)

7-AGE.

25 yrs. *7* mos. *7* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION.

(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country).

Baltimore

PARENTS.

10-NAME OF FATHER.

Wm Lindler

11-BIRTHPLACE OF FATHER. (State or Country).

Russia

12-MAIDEN NAME OF MOTHER.

Conidia Kramer

13-BIRTHPLACE OF MOTHER. (State or Country).

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. Lindler*(Address) *1804 E. Baltimore*

15-

*OCT - 3 1915**ROBERT J. KRAUTER*Filed *1915* *Oct 3* *1915* *Regist.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

October *2*, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *November 1914*, to *Oct. 2* *1915*, that I saw her alive on *October 2* *1915*, and that death occurred, on the date stated above, at *1 P.* m. The CAUSE OF DEATH* was as follows:
Chronic Intestinal
(Duration) *7* yrs. *7* mos. *7* ds.
CONTRIBUTORY (Secondary) *Chronic Intestinal*
(Duration) *7* yrs. *7* mos. *7* ds.
(Signed) *P. Lindler* M. D.
at 2, *1915* (Address) *2407 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *7* yrs. *7* mos. *7* ds. Is the State *7* yrs. *7* mos. *7* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Deben Washington *Oct 3*, *1915*

20-UNDERTAKER

ADDRESS

Jack Lure *1419 E. Baltimore*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

56 C88591
REGISTERED NO. C

1-PLACE OF DEATH

Baltimore

2-CITY OF BALTIMORE (No.

47 N. Broadway

ST.

WARD)

3-FULL NAME

Jacob Cohen

(Residence in Baltimore: No.

47 N. Broadway

ST.

YRS.

MO.

DS.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

October 1, 1870

(Month)

(Day)

(Year)

7-AGE

45

YRS.

MO.

DS.

If LESS than

1 day, hrs.

or — min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

Clothing

9-BIRTHPLACE

(State or country)

Russia

10-NAME OF FATHER

Isabel Cohen

11-BIRTHPLACE OF FATHER
(State or country)

Russia

12-MAIDEN NAME OF MOTHER

Zelda Jacobs

13-BIRTHPLACE OF MOTHER
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jacob Cohen

(Address)

47 N. Broadway

15

OCT - 3 1915

Filed

JOSEPH J. KRAUTER

City of Baltimore Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Oct 3, 1915

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY. That I attended deceased from

Oct 1, 1915, to Oct 3, 1915

that I saw him alive on

Oct 3, 1915

and that death occurred, on the date stated above, at

10 m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

1 ds.

(Signed) Henry J. ... M.D.
Oct 3, 1915 (Address) 1610 E. 13th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Hebrew Burial

DATE OF BURIAL

Oct 5, 1915

20-UNDERTAKER

Jacob Cohen

ADDRESS

1419 E. 13th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 Fleet ST. 1 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1811 Fleet St.; 1 hour yrs., 1 mos., 1 da.)REGISTERED NO. C 88592

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

October

2

1915

(Month)

(Day)

(Year)

7-AGE,

If LESS than 1 day,

1 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Maryland Balt

PARENTS.

10-NAME OF FATHER,

Max Dzywanowsky

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Dora Inabowsky

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Max Dzywanowsky

(Address)

1811 Fleet St.

15-

OCT - 3 1915

JOSEPH E. KRAUTER

Notary Public

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

October

2

1915

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 2

1915

to Oct 2

1915

that I saw him alive on October 2 1915

and that death occurred, on the date stated above, at 1:00 p.m.

The CAUSE OF DEATH* was as follows:

Atelectasis

CONTRIBUTORY

Ascites

(Duration) yrs. mos. da.

Congenital anomaly

(Duration) yrs. mos. da.

(Signed) John G. Murray M. D.

Oct 2 1915 (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Oct 3, 1915

20-UNDERTAKER

William Fialkowski 1618 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88593

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH *529 Bruce St.*
 CITY OF BALTIMORE: (No. *529 Bruce* ST.; WARD) *17*
 2-FULL NAME *Inf of Jerome & Alberta Maurer*
 (Residence in Baltimore: No. *529 Bruce St.* St.; yrs. mos. *6 mos.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Col* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
 6-DATE OF BIRTH, *10 - 2 - 1915*
 (Month) (Day) (Year)
 7-AGE, *6 yrs. or less*
 yrs. mos. ds. IT LESS than 1 day.

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *None*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore Md.*

10-NAME OF FATHER, *Jerome Maurer*

11-BIRTHPLACE OF FATHER (State or Country), *Baltimore Md.*

12-MAIDEN NAME OF MOTHER *Alberta Hawkins*

13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jerome Maurer*
 (Address) *529 Bruce St.*

15- *OCT - 3 - 1915*
 Filed *ROBERT KRAUTER*
 Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *10 - 2 - 1915*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct 2nd* 1915, to *Oct 2nd* 1915, that I saw him alive on *Oct 2nd* 1915, and that death occurred, on the date stated above, at *11 a m.*

The CAUSE OF DEATH* was as follows:

Pneumonia + malnutrition
 (Duration) yrs. mos. ds. *6 mos.*

CONTRIBUTORY (Secondary) *Debility*

(Duration) yrs. mos. ds.

(Signed) *L. W. Barker* M. D.

Oct 2nd 1915 (Address) *1403 W. Linnell St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Mt Auburn cemetery *Oct 3rd* 1915

20-UNDERTAKER

Walter Owens

ADDRESS

318 Myrtle Ave

14. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C88594

HEALTH DEPARTMENT—CITY OF BALTIMORE

C88594

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *933 Payco Ct* ST. *14* WARD) *79*
2-FULL NAME *Mary E. Williams*
(Residence in Baltimore: No. *933 Payco Ct* St.; yrs. *life* mos. *0* ds. *0*)

REGISTERED No. C...
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Female</i>	4-COLOR OR RACE, <i>Col</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>Single</i>
6-DATE OF BIRTH, <i>Nov 6, 1871</i> (Month) (Day) (Year)		
7-AGE, <i>43 yrs. 10 mos. 10 ds.</i>		8-LESS than 1 day, ... hrs. or ... min.?
9-OCCUPATION: (a) Trade, profession, or particular kind of work, <i>Housework</i> (b) General nature of industry, business, or establishment in which employed (or employer).		
10-BIRTHPLACE, (State or Country), <i>Balto</i>		
PARENTS.	10-NAME OF FATHER, <i>John H. Williams</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Balto</i>	
	12-MAIDEN NAME OF MOTHER, <i>Mariah Durall</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>unknown</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John H. Williams*
(Address) *933 Payco Ct.*

15-*OCT - 3 1915*
Filed *1915* *10:15* *1915*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 1, 1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* and that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows: *Acute Cordial Dil*

(Duration) *Org. Heart disease* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary) *Org. Heart disease* (Duration) *0* yrs. *0* mos. *0* ds.

(Signed) *Oct 3 1915* (Address) *101 N. Carroll St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Mount Auburn* DATE OF BURIAL, *Oct 3rd 1915*

20-UNDERTAKER, *John Brown & Co* ADDRESS *901 Hilltop*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *840 Coke Alley*)

ST. *10* WARD)

2-FULL NAME

Joseph W Wiley

(Residence in Baltimore: No. *840 Coke Alley*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Infant

6-DATE OF BIRTH,

Jan 6th, 1915
(Month) (Day) (Year)

7-AGE,

8 yrs., 2 mos., 25 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Infant

9-BIRTHPLACE, (State or Country),

Balt Md

10-NAME OF FATHER,

William Wiley

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Carrie Slater

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Carrie Slater

(Address)

840 Coke Alley

15-

OCT - 3 1915

ABERT KRAUTER

Filed

Vol.

Serial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 30th, 1915
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest*
(Inquest, au-

Inquest find that said deceased came to his death
topsy or inquiry.) on the day stated above.

THE CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Natural Causes

(Duration) yrs. mos. ds.

(Signed) *Elyah J Russell* M. D.
(Coroner.)

Sept 30th, 1915 (Address) *423 N Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence,

19-PLACE OF BURIAL, OR REMOVAL,

Laurel Cem

DATE OF BURIAL,

Oct 3rd, 1915

20-UNDERTAKER

ADDRESS

Harry A Vodery 1725 Orleans St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 529 Columbia Av 22 WARD)2-FULL NAME Vincent Prebis

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 529 Columbia Av St. yrs. mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE Single
~~MARRIED~~
~~WIDOWED~~
~~OR DIVORCED~~6-DATE OF BIRTH Sept. 30 1915
(Month) (Day) (Year)7-AGE 3 If LESS than 1 day, hrs. min.?
yrs. mos. ds. or min.?8-OCCUPATION None
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE Balti, Md.
(State or country) 529 Columbia Av10-NAME OF FATHER Vincent Prebis11-BIRTHPLACE OF FATHER Russia
(State or country)12-MAIDEN NAME OF MOTHER Elizabeth Jurgaitis13-BIRTHPLACE OF MOTHER Russia
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vincent Prebis(Address) 529 Columbia Av

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Oct. 2 1915
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 30, 1915, to, Oct 2 1915
that I saw him alive on Oct 2 1915
and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) yrs. mos. 3 ds.

Contributory (SECONDARY)

(Signed) John J. Skladoghy M. D.
Oct 2, 1915 [Address] 529 Columbia Av

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence 529 Columbia Av19-PLACE OF BURIAL OR REMOVAL Holy RedeemerDATE OF BURIAL Oct 3 191520-UNDERTAKER John J. SkladoghyADDRESS 212 S. Paca St.

15-

OCT - 3 1915

J. S. KRAUTER,
Official Permit Clerk
REGISTRAR

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST.; *9* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1102 E. North Ave* St.; *Life* yrs., *Life* mos., *Life* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 14.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

October 20, *1867*
(Month) (Day) (Year)

7-AGE

47 yrs., *11* mos., *12* ds.IF LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Housewife*9-BIRTHPLACE,
(State or Country),*Md. Balto.*

PARENTS.

10-NAME OF FATHER,

*Henry Westphal*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Schmidt*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. J. Wright
Hamilton Md.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct. 20, *1915*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept. 29* 191*5*, to *Oct 1* 191*5*, that I saw h*er* alive on *Oct 1* 191*5*, and that death occurred, on the date stated above, at *3:30* A.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration).....yrs. *10* mos.ds.CONTRIBUTORY
(Secondary)(Duration).....yrs.mos. *3* ds.

(Signed)

H. M. Cullough, M. D.
Oct 1, 1915, 191... (Address) *St. Joseph's Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *2* ds. In the *47* yrs. mos. ds. StateWhere was disease contracted, if not at place of death? *1102 E. North Ave*Former or usual residence *1102 E. North Ave*

19-PLACE OF BURIAL OR REMOVAL,

Greenwood Cemetery

DATE OF BURIAL,

Oct 5, 1915

20-UNDERTAKER

Henry Hock Son

ADDRESS

1301 E. Bay St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15-

*OCT. 3, 1915**ROBERT**KRAUTER,*

Registrar

C88598

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 C88598

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2319 Frederick Ave* ST.; *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2319 Frederick Ave* St.; *44* yrs., *5* mos. *25* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

April *5th*, *1871*
(Month) (Day) (Year)

7-AGE,

44 yrs., *5* mos., *25* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*Carpenter*9-BIRTHPLACE,
(State or Country),*Balto. Md.*

10-NAME OF FATHER,

*Conrad Schwanneke*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Barbara Albert*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Miss Dorothea Schwanneke

(Address)

2319 Frederick Ave

15-

OCT - 3 1915

ROBERT KRAUTER,

Chief Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct *1*, *1915*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 10 *1915*, to *Oct 1* *1915*,that I saw him alive on *Oct 1*, *1915*,and that death occurred, on the date stated above, at *2-12* m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) *Walter A. Cox* M. D.*1012*, *1915* (Address) *Barriar, Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs..... mos..... ds. In the State yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL,

Oct 3, *1915*

20-UNDERTAKER,

Geo. L. Schwab & Bro.

ADDRESS

2101 Frederick Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 Wilkins St. ST. 19 WARD)

2-FULL NAME

(Residence in Baltimore: No. 143 Wilkins St. St.; 41 yrs., - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
(Write the word.)

6-DATE OF BIRTH, June 4, 1859
(Month) (Day) (Year)

7-AGE, 56 yrs., 3 mos., 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Cement worker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), York Pa.

10-NAME OF FATHER, Anthony Jacob Shanbrook

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Muriel Heagerty

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane B. Shanbrook

(Address) 143 Wilkins St.

15- OCT. - 3, 1915 JOSEPH H. KRAUTER,

Filed OCT. - 3, 1915 JOSEPH H. KRAUTER,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1915, to Oct 2 1915, that I saw him alive on Oct 2 1915, and that death occurred, on the date stated above, at 1:30 P.M. The CAUSE OF DEATH* was as follows:

Clinical Diagnosis
Carcinoma of Lung
(Duration)..... yrs. mos. ds. unknown

CONTRIBUTORY (Secondary).....

(Signed) Walter A. Cox M. D.
10. 3, 1915 (Address) Garrison Pl. N. 11 A

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Landon Park DATE OF BURIAL, Oct. 4, 1915

20-UNDERTAKER, Geo. L. Schwab & Bro. ADDRESS, 2101 Frederick Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.



CITY HALL
BALTIMORE 2, MARYLAND

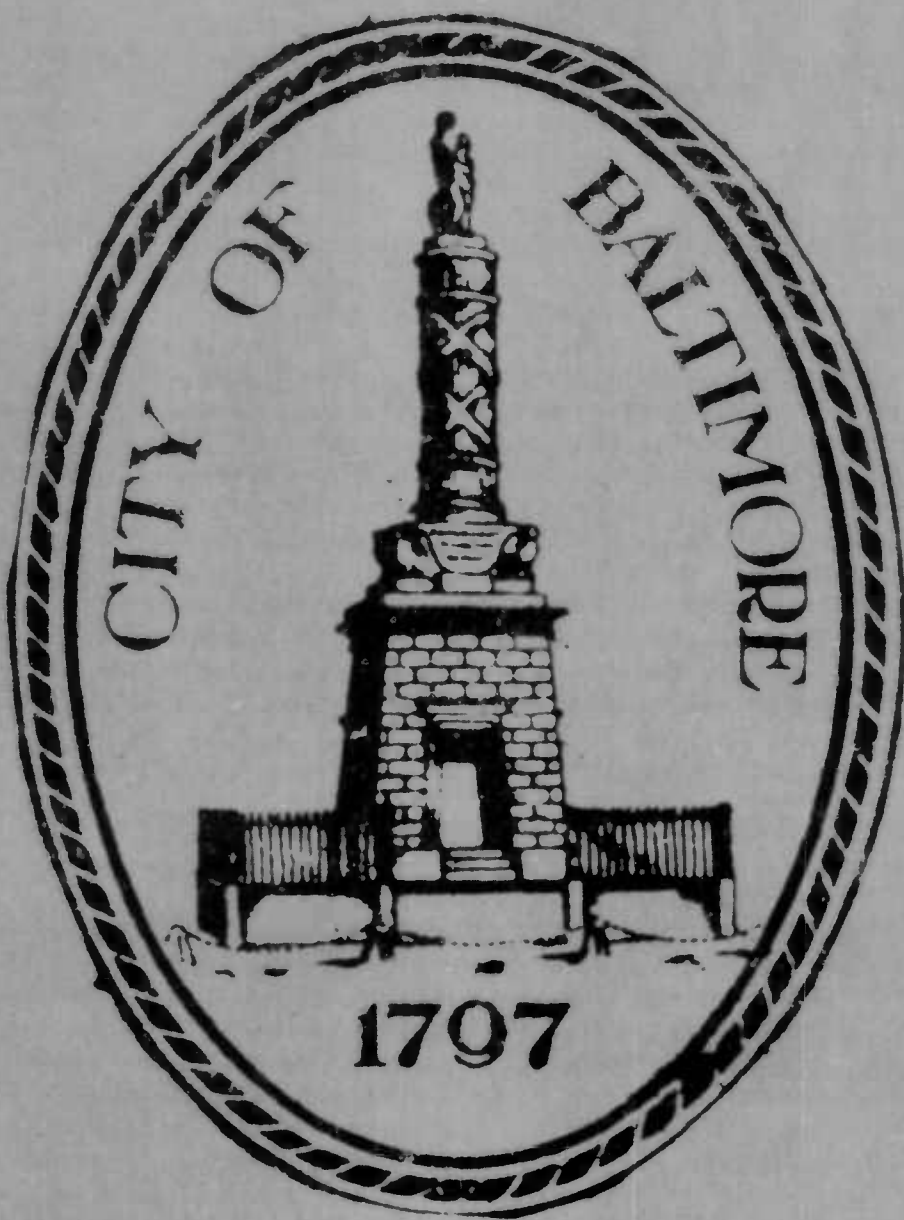
DEPARTMENT OF LEGISLATIVE REFERENCE
RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 20th DAY July
OF 1964 THE MICROPHOTOGRAPHS APPEARING
HEREIN STARTING WITH C85351 AND 16, 1915
ENDING WITH C-88599 - Reg. Oct 15, 1915 ARE AC-
CULATE AND COMPLETE REPRODUCTIONS OF THE
RECORDS OF THE DEPARTMENT OF Health
BUREAU OF Vital Statistics AS DELIVERED
IN THE REGULAR COURSE OF BUSINESS FOR
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
COPY.

CAMERA OPERATOR: L. Pryor



END OF REEL